

# REQUEST FOR TRANSCRIPT

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Maiden Name \_\_\_\_\_



**SANFORD MEDICAL CENTER, SCHOOL OF RADIOLOGIC TECHNOLOGY**  
1305 W. 18<sup>th</sup> St., Sioux Falls, SD 57117-5039  
Phone (605) 333 – 6466 / (605) 333-7445  
Fax (605) 333-1554

Date \_\_\_\_\_ No. of Copies \_\_\_\_\_

Are you currently enrolled at Sanford? Yes  No

If "NO", Date of graduation \_\_\_\_\_

Phone or E-mail address \_\_\_\_\_

Send / Release transcript to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_

NOTE: ONE ADDRESS PER TRANSCRIPT REQUEST

*For office use only*  
Request taken by \_\_\_\_\_ Date Sent/Released \_\_\_\_\_

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