



SCHOOL OF HEALTH
RELATED PROFESSIONS

University of Medicine & Dentistry of New Jersey

Office of Enrollment Services

TRANSCRIPT REQUEST FORM

Please Print Legibly:

Student ID#: _____ First Name: _____ M: _____ Last Name: _____

Daytime Phone #: (____) _____ Home Phone: (____) _____ Email Address: _____

Program/Major: _____ If Joint Program, Affiliate Name _____ Term: (ex: Fall 2004) _____

Program Attended: _____ Dates Attended: _____ Term/Year _____ Term/Year _____

Student Type (circle one): Graduate Undergraduate Non-Matriculate Pre-College

Currently Enrolled? Yes No Graduation Date _____, _____

Were you enrolled in the High School Tech Prep Program? Yes No

** If yes, what high school did you attend while taking classes? _____

Mail Transcript immediately Please hold from processing this transcript request until: _____, _____

Reason for Transcript Hold: _____

Transcript Type to be sent: Unofficial Transcript Official Transcript

**** Official Transcripts will not be released to students/alumni****
***** Transcripts will not be released to any student with encumbrances**
(i.e. outstanding balance, Financial Aid Exit Interviews, overdue library books)***

Send Transcript(s) to:

Request #1:

Request #2 (Optional):

Authorization for Release of Transcript

Name Enrolled As: _____
Student Signature: _____ Date: _____

Transcript Release Comments: _____

ENROLLMENT SERVICES USE ONLY

Enrollment Services signature _____ Date Processed _____ Date Sent _____