Stritch School of Medicine Transcript Request Form

LOYOLA UNIVERSITY CHICAGO **STRITCH SCHOOL OF MEDICINE** Office of Registration & Records (ORR)	2160 South First Avenue Bldg. 120, Rm. 220 Maywood, IL 60153 Phone: (708) 216-3222; Fax: (708) 216-8151

1) Name:			
2) Other Names Used/Under Which Records May Appear:			
3) Date of Birth:		4) Year of Graduation:	
5) Check if presently enrolled: ❑ (IF currently enrolled skip to #7)			
OR Provide:			
6) Address:		Phone:	
CITY	STATE	ZIP CODE	
7) Number of Transcripts Requested:			
8) Send transcript(s) to: (For SSOM faculty, provide name & department) **OR Pick-up:**			

DATE

**For additional addresses, please use an attachment—
preferably mailing labels addressed to the appropriate institution(s).**

9) Send transcript:			
	❑ As soon as possible	❑ Upon posting degree	
	❑ Other: Please specify		

10) Send Dean's letter: Yes ❑ No ❑	Please note: Dean's Letters **cannot** be released directly to the student/graduate.
If yes, reason for Dean's letter:	

11) Check type of transcript requested:

		OFFICIAL – Carries school seal and Registrar's signature. In order to be valid, must be mailed directly from ORR to requested destination *or* transmitted to 3rd party in ORR sealed envelope with signature across the back flap.
		OFFICIAL Issued to Student – given directly to student.

Signature authorizing release of transcript:

SIGNATURE		DATE

In accordance with the Federal Education Rights and Privacy Act of 1974, further release of this transcript without the written consent of the student or graduate is prohibited.

Office Use Only	Date mailed/ released: _____	Initials: _____