St. Elizabeth
SCHOOL OF NURSING

Division of Franciscan Health

TRANSCRIPT REQUEST FORM: Complete and return this form to the address below.

Date: _____ **Student ID Number or SS#** _____

_____ _____ _____ _____

Last Name **First Name** **Middle Initial** **Maiden Name**

Please List **All Last Names** that you may have used on records: _____

_____ _____ _____ _____

Street Address **City** **State** **Zip**

_____ _____ _____ _____

Home Phone **Cell Phone** **Work Phone** **E-mail Address**

Is this Street Address New: ☐ Yes ☐ No Date of Birth: _____

Did your Graduate from St. Elizabeth: ☐ **YES** ☐ **NO** If **YES**, Month and Year: _____

If **NO**, Dates of Attendance _____to _____

I request my official transcript be sent to ☐ myself ☐ the person(s) at the address(es) below.

Because this information is protected by confidentiality rules, it must be sent to a specific person. **A transcript fee of $10.00 per transcript shall be charged.** Charges must be paid prior to documents being sent. Make check payable to **ST. ELIZABETH SCHOOL OF NURSING.**

Please Note: because this is protected confidential information, the School **WILL NOT FAX** any part of your requested record information to a Third Party.

Transcript is to be sent to:

Copy 1

_____
Name

_____
College, Hospital or Receiving Agency

_____
Address

_____
City, State, Zip

Copy 2

_____
Name

_____
College, Hospital or Receiving Agency

_____
Address

_____
City, State, Zip

For additional transcripts, please attach additional page(s) with name and address to whom transcripts are to be sent.

_____ _____
Signature Date

Send This Request Form To:

Registrar
St. Elizabeth School of Nursing
1501 Hartford Street
Lafayette IN 47904-9988