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.

________ UNOFFICIAL – given to student, marked "Unofficial."

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.

Please do not send transcript requests via email.

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