



SCHOOL OF NURSING

University of Medicine & Dentistry of New Jersey

TRANSCRIPT REQUEST FORM

Please print legibly or type:

Date: _____

First Name _____ Middle Name: _____ Last Name: _____

Student ID#: A00 _____ Program/Major: _____ If Joint Program, Affiliate: _____

Daytime Phone #: (____) _____ Home Phone #: (____) _____ Cell Phone #: (____) _____

E-mail Address: _____

Term (ex: Fall 2006): _____ Program Attended _____ Dates Attended _____ - _____

Name enrolled as: _____

Student Type (Select one) Graduate Undergraduate Non-Matriculate

Currently enrolled? Yes No

Graduation Date: January May September Year _____

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 directly to students/alumni

* Transcripts will not be released to any student with encumbrances (i.e. outstanding balance, Financial Aid or Student Loans Exit Interviews, overdue library books)

Send Transcripts to:

Request #1:

Request #2:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Transcript Release Comments: _____

Return form to School of Nursing Enrollment Services • 65 Bergen Street, Room 152 • PO Box 1709 • Newark, NJ 07101

Phone: 973-972-5336 • Fax: 973-972-7453

Student Signature: _____ **Date:** _____

ENROLLMENT SERVICES USE ONLY

Enrollment Services signature _____ Date Processed _____ Date Sent _____