ST. CLOUD HOSPITAL
SCHOOL OF DIAGNOSTIC IMAGING

1406 Sixth Avenue North
St. Cloud, MN 56303-1901
320-255-5719

Transcript Request
$5.00 PROCESSING FEE
Make check or money order payable to SCH

Social Security_____ Number of copies required_____

Former Name (if applicable)_____ Years Attended_____

Student's Name and Address:

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Signature_____ Date of Request_____

Mail Transcript to:

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Official transcripts will be sent by mail ONLY to potential employers, other schools or agencies at the direction of the requestor. All transcripts ISSUED TO THE STUDENT will not be signed and will be marked "Issued to Student".

OFFICE USE ONLY
FEE PAID$_____

DATE MAILED_____