

Lourdes Institute of
Wholistic Studies
900 Haddon Avenue
Suite 114
Collingswood, NJ 08108

**TRANSCRIPT
REQUEST
FORM**

Lourdes Institute
Registration Office
(856) 869-3134
Fax (856) 869-3139

Instructions:

- Please print clearly with pen. Complete all items.** Use a separate form for each addressee. Submit this form to LIWS Registration Office.
- Submit payment of fee** (\$10.00 per recipient address) to the Registration Office. Make check payable to *Our Lady of Lourdes Medical Center*. No transcript request can be honored for a student whose financial obligation to the institute has not been satisfied. Transcript requests will be processed after fee has been received.
- Print student's name and current address** in the box to the **RIGHT**. Print clearly. The student's transcript will be sent to the indicated address, and a complimentary copy to the student for their records. →→→→
- Print student's social security number: _____ - _____ - _____
- List maiden name or other names used at Lourdes Institute:**
It is the student's responsibility to notify the recipient of the transcript of the name under which the transcript was recorded. _____
- Please sign and date:**
I request that an official transcript(s) be sent to the address listed to the RIGHT:

Student Signature _____
Date _____
- Please print in the box to the RIGHT the exact name and address where the official transcript is to be mailed.** →→→→→→→→→→→→→→

Student's _____
Name LAST FIRST MIDDLE

Address: _____ Apt. # _____

City: _____ State: _____ ZIP: _____

RECIPIENT OF TRANSCRIPT:

Recipient's
Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Attn: _____

INSTITUTE OFFICE USE ONLY

Date received: _____

Date mailed: _____