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:

1. **Please print clearly with pen. Complete all items.** Use a separate form for each addressee. Submit this form to LIWS Registration Office.
2. **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.
3. **Print student's information** 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.➔➔➔
4. Print student's social security number: ___ ___ ___ - ___ ___ - ___ ___ ___
5. **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. ____________________________
6. **Please sign and date:**
   I request that an official transcript(s) be sent to the address listed to the RIGHT:

   Student Signature ____
   Date ______________________
7. **Please print in the box to the RIGHT the exact name and address where the official transcript is to be mailed.** ➔➔➔➔➔➔➔➔➔➔➔➔

INSTITUTE OFFICE USE ONLY

Date received: ______________

Date mailed: ______________

Student's Name ____
LAST FIRST MIDDLE

Address: ____

City: ________________________ State: ______ Zip: __________

Telephone: ____

Email Address: ____

RECIPIENT OF TRANSCRIPT:

Recipient's Name: ____

Address: ____

____

City: ________________________ State: ______ Zip: __________

Telephone: ____

Email Address: ____

Attn: ____