Date_____

Kettering College of Medical Arts

TRANSCRIPT REQUEST

3737 Southern Blvd.
Kettering, OH 45429
(937) 298-3399 ext. 55615

Are you currently attending KCMA? ❑ Yes ❑ No If not, when did you last attend? Semester_____ Year_____

Please print YOUR NAME AND MAILING ADDRESS BELOW FOR USE IN A WINDOW ENVELOPE (Include zip code)

_____
First Middle Maiden Last

_____
Street Address

_____
City State Zip

There is a minimum preparation period of 1 week on transcript requests.

Transcripts may not be released until all outstanding KCMA financial obligations are cleared.

At each time of requesting transcripts, there is a $5 fee per copy.

_____
Signature of Sutdent

_____
Phone Number

_____
Social Security No.

_____
E-mail

I need the following transcript/s:

❑ Mail transcript now.

❑ Mail transcript at the end of this semester.

❑ Special instructions_____

___ Number of copies to be sent to address below. (Include zip code)

Please print

_____
_____
_____
_____
_____

If transcripts are to be sent to more than one address, use additional forms.

Office use only

Date Transcript

_____ mailed

_____ to be picked up on

Transcript fee due:

Previous Balance-Dr/Cr $_____

This Request- $_____

Current Balance-Dr/Cr $_____

Paid $_____ Rec#_____

MAILED WITH TRANSCRIPT