MLMH Request for Transcript

School of Radiologic Technology

Print Name ____
Last First Middle Former Name

Address ____
Street City State Zip

Number of Transcripts this request ________ (Include $5.00 for each transcript)

______________________________ ______________________
Signature Date

____________________ ____________________ ____________
Phone Social Security # Date of Birth

Special Instructions: ____

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Mail transcripts to: (Official transcripts, those bearing a raised seal, may only be sent to a college/business. Unofficial transcripts may be sent to the individual.)

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This information is provided with the understanding that the recipient, if other than the student, will not disclose the information to any other party without prior consent of the student as required by the Family Education Rights and Privacy Act of 1974.

Please make check payable to: Mary Lanning Memorial HealthCare

Mail to: Education Department
Mary Lanning Memorial HealthCare
715 N. St. Joseph Ave.
Hastings, NE 68901