



Transcript Request

Student Records • 3575 College Road • Harrisburg, IL 62946

Telephone: 618-252-5400 ext. 2434 • Fax: 618-252-3062

_____	_____	_____	_____
Email	Student ID #	Date of Birth	Dates of Attendance
_____	_____	_____	_____
Last Name	First Name	Initial	Previous Name(s)
_____	_____	_____	_____
Address	City	State	Zip
_____	_____	_____	_____
			Phone

By this signature, I agree to the release of my academic records to the recipient indicated below:

_____	_____
<i>Signature</i>	<i>Date</i>
Name or Office: _____	
Institution or Business: _____	
Mailing Address: _____	
City/State/Zip: _____	

Check **all** that apply:

- _____ Hold for _____ semester's grades
- _____ Hold for grade change in _____
- _____ Hold for degree/certificate to be posted
- _____ Please mail immediately
- _____ I will pick up the transcript

How many copies? _____ Official Transcript (\$5.00) _____ Student Copy (free)

Please allow at least two business days for processing. Will be processed in the order received.

Visa () Mastercard () Discover ()
 Credit Card Number _____
 Expiration Date _____
 Verification # _____
 Amount of Charge _____
 Cardholder Phone# _____

Please include debit or credit card info if faxing a request.

Amount paid: _____