LOUISIANA STATE UNIVERSITY HEALTH SCIENCES CENTER
SCHOOL OF ALLIED HEALTH PROFESSIONS
Office of Student Affairs
1900 Gravier Street, New Orleans, LA 70112

TRANSCRIPT REQUEST FORM

TO THE APPLICANT: Complete the information below and send this form and a self-addressed envelope to the Registrar of each college and university you have attended. Request TWO copies of your official academic record. When you receive the completed form and academic records in the SEALED envelope, include it UNOPENED with the materials you submit with your application.

DO NOT OPEN THE ENVELOPE WHEN IT IS RETURNED TO YOU BY THE REGISTRAR

Name:_____
Last First Middle

If you attended college/university under another name, please provide: _____

Current
Address: _____

Social Security Number: _____

Name of College or University: _____

School Attended within the University: _____

Dates of Enrollment: From _____ To _____
month/year month/year

Degree, Major and Year: _____

STUDENT'S
SIGNATURE _____

TO THE REGISTRAR: The person named here is applying for admission to the School of Allied Health Professions, Louisiana State University Health Sciences Center. We appreciate your cooperation inour self-managed application process. Please attach TWO copies of the student's official academic records to this form and mail to the APPLICANT in the envelope provided. Please return in the SEALED envelope to the applicant who will submit it UNOPENED to the Office of Student Affairs, LSUHSC School of Allied Health Professions, 1900 Gravier Street, New Orleans, LA 70112.

_____ _____
Registrar's Signature Date