TRANSCRIPT REQUEST

Graduate Name: Date:

________ I request 1 *unofficial* copy of my transcript be sent to me.

OR

________ I request that 1 *official* copy of my transcript be sent to:

Name of Institution: ____

Attention to: ____

Address of Institution: ____

City/State/Zip Code: ____

Signature of Graduate/Student: ______________________________________

Date

TRANSCRIPT FEE

NOTE: You must enclose a check or money order for $5.00 per transcript whether official or unofficial, (**do not send cash**) made out to:

Rapid City Regional Hospital

Medical Radiography Program

POB 6000

Rapid City SD 57709-6000