Augusta HEALTH
School of Clinical Laboratory Science

Transcript Request

A transcript request form must be completed for each different person/organization to whom an official transcript is to be sent. Email completed transcript request forms to Ann Ridder at aridder@augustahealth.com; mail to 78 Medical Center Drive, Fishersville, Virginia, 22939; or fax to 540-332-4543.

Please print clearly.

Full Name: _____Date: _____

Full Name at time of program completion (if different than above): _____

Last Four of SSN: XXX-XX- _____ Date of Birth (mm/dd/yyyy):_____

Current Address: _____

Phone Number: _____ Email: _____

Dates of Attendance/Graduation: _____

Send Transcripts to: Number of Copies Requested: _____

Name: _____

Address: _____

_____

_____

Special Instructions: _____

_____

By signing below, I authorize the release of my academic records to the person/organization named on this form.

Student/Graduate Signature (required): _____Date: _____

Notes: Allow five business days for processing. You may contact the school at 540-332-4539 to check the status of your request. This form may be used for students/graduates of: Augusta Health School of Clinical Laboratory Science, Augusta Medical Center School of Clinical Laboratory Science, and King's Daughters' Hospital School of Medical Technology.