American University of St. Vincent — School of Medicine
Office of the Registrar
17950 Preston Road, Suite 420, Dallas, TX 75252
registrar@aussom.org

Transcript Request Form

Print your name and address

Name: _____
Last First Middle Initial

Address: _____
Street

_____
City State Zip Code

_____
Email Address Phone #

Hold for current semester grades? ☐ Yes ☐ No _____
Specify Semester

Graduated: ☐ Yes ☐ No If yes, date: _____ Degree _____

Transcript requested: ☐ Official Copy (sent to recipient below) ☐ Student Copy (sent to the student, unofficial)

Please send an official transcript of my academic records from: _____ to _____
to the address indicated below:

Print full name and address below of recipient

Name: _____
University/College Name

Attn: _____
Name

Address: _____
Street

_____
City State Zip Code

Reason for Official Transcript:_____

Official transcripts are $ 25.00 per copy. Student copies are free.

Official Transcript requests will not processed without the required payment. Transcripts are sent out within 5 business days.

_____ _____
Student Signature Date

Credit Card Information

Credit Card Number: _____
Expiration Date: _____ 3 Digit Code: _____
Card Holders Name: _____
Card Holder Signature: _____
Amount Authorized to be charged: _____

By signing above, I give authorization to American University of St. Vincent (AUS) to charge my credit card.

Office only

Finance Office_____Paid _____

Registrar Office_____Sent _____