# BOSTON UNIVERSITY SCHOOL OF MEDICINE
# OFFICIAL TRANSCRIPT REQUEST

Boston University School of Medicine
Office of the Registrar
72 E. Concord Street, Room A414
Boston, MA 02118
(617) 358-7552

_____ _____ _____
Name Signature Date

_____
Address

_____

_____

_____
I.D. Number or last 4 digits of Social Security#

_____
College/School

_____
Dates of Attendance

_____
Former Name *(If applicable)*

**PURPOSE OF TRANSCRIPT REQUEST:**

_____ Professional Certification *(Licensure, Scholarship, etc. – Transcripts mailed to you will be issued in a signed and sealed envelope)*
_____ Transfer
_____ Personal/Other *(Transcripts mailed to you will be marked Student Issued)*

_____ Hold for: ____ Fall ____Spring Grades: *(Check appropriate semester)*
_____ Hold for: ____ May Graduation

**PLEASE PRINT COMPLETE ADDRESS FOR TRANSCRIPT DESTINATIONS BELOW:**

Destination 1: Number of Copies _____

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Destination 2: Number of Copies _____

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Destination 3: Number of Copies _____

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Destination 4: Number of Copies _____

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Requests for medical school transcripts should be sent to:
**The Office of the Registrar - Boston University School of Medicine**
**72 E. Concord Street, Room A414**
**Boston, MA 02118**
**Fax: (617) 358-7551**