BOSTON UNIVERSITY

Chobanian & Avedisian School of Medicine

OFFICIAL TRANSCRIPT REQUEST

_____ _____ _____

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 _____

_____

_____

_____

_____

Destination 2: Number of Copies _____

_____

_____

_____

Destination 3: Number of Copies _____

_____

_____

_____

_____

Destination 4: Number of Copies _____

_____

_____

_____

Requests for medical school transcripts should be sent to:

Boston University Chobanian & Avedisian School of Medicine
The Office of the Registrar
72 E. Concord Street, Room A414
Boston, MA 02118
Phone: (617) 358-7552
Fax: (617) 358-7551