BOSTON UNIVERSITY

Chobanian & Avedisian School of Medicine

OFFICIAL TRANSCRIPT REQUEST

Name _____

Address _____

_____

_____ _____

Signature Date

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:

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
Email: camedreg@bu.edu