BOSTON UNIVERSITY

Chobanian & Avedisian School of Medicine

OFFICIAL TRANSCRIPT REQUEST

Name

Address

Email

Signature Date

BU I.D. # or Date of Birth

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

PLEASE PRINT COMPLETE EMAIL OR 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:

Email: camedreg@bu.edu

U.S. Mail:

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