

Office Use Only
Date Received: _____
Date Mailed: _____

FCS TRANSCRIPT REQUEST FORM
Enrolled Seniors 3 Free, Additional \$5 per transcript
Alumni & All Others \$5 per transcript

Student Name: _____

SSN: _____

Year of High School Graduation: _____

Contact Phone Number: _____

Reason for Request: College School Transfer Insurance Other
(Please circle one)

Names & addresses* of Colleges/Universities/Organizations/Persons requiring transcript:

1) Name: _____

Address: _____

2) Name: _____

Address: _____

3) Name: _____

Address: _____

* Request will not be processed unless a mailing address is provided!

Attach an additional sheet of paper if more space is needed for names and addresses.

Application/Postmark Deadline: _____

If there are any special instructions or reminders related to this request or your application, please write them in the space below:

Signature of Person Requesting Transcript: _____

Date: _____ Relationship to Student _____

You must allow 5 business days, from the date this form is received in this office, for the transcript request to be processed and mailed.

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