

# Transcript Request Form

Once complete send this form to one of the following:

- Fax - 419-251-0629
- E-mail - [registrar@mercycollege.edu](mailto:registrar@mercycollege.edu)



## STUDENT INFORMATION

Name: \_\_\_\_\_  
First Middle Initial Last

Student ID #: \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### PLEASE INDICATE WHICH INSTITUTION YOU ATTENDED:

- ☐ Mercy College of Ohio
- ☐ Mercy College of Northwest Ohio
- ☐ Mercy School of Nursing
- ☐ St. Vincent School of Nursing
- ☐ St. Vincent School of Radiography

### PLEASE LIST ANY OTHER NAMES YOU HAVE USED:

\_\_\_\_\_

### DATES ATTENDED OR YEAR GRADUATED:

\_\_\_\_\_

### SEND TRANSCRIPTS DIRECTLY TO:

Name of Organization: \_\_\_\_\_

Attn: \_\_\_\_\_ # of Transcripts: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

*MERCY COLLEGE OF OHIO IS UNABLE TO EMAIL TRANSCRIPTS AT THIS TIME.*

The Office of Student Records has my permission to send this transcript to the individual or organization above.

Student Signature \_\_\_\_\_

Date \_\_\_\_\_

Office: Student Records

Last Updated: 08/14/2019

Processed by: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Initials \_\_\_\_\_