Transcript Request Form

Once complete send this form to one of the following:

- Fax - 419-251-0629
- E-mail - registrar@mercycollege.edu

Mercy College of Ohio

STUDENT INFORMATION

Name: _____ _____ _____
First Last Middle

Street Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Date of Birth: _____

Student ID: _____ Email: _____

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 Medical 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: 4/11/2017

Processed by: _____ Date: _____
Staff Initials