THE COLLEGE OF NEW ROCHELLE
Office of the Registrar

TRANSCRIPT REQUEST FORM

Allow 7 –10 business days for processing. Expect delays at the beginning and end of semesters.
Note: FILL OUT CLEARLY AND COMPLETELY

X _____
STUDENT'S SIGNATURE

HOME NUMBER: _____

CELL NUMBER: _____

E-MAIL ADDRESS: _____

HOME ADDRESS

Name: _____

Address: _____

Address: _____

City: _____ State: _____ ZIP:_____

☐ Check here if address needs to be updated.

INFORMATION OF ORGANIZATION/INSTITUTION

ADDRESS TO BE SENT: (*Print clearly. This form will be used to mail your transcript.*)

Please: Complete a separate request for each institution.

Organization: _____

Attn: _____

Address: _____

City: _____ State: _____ ZIP:_____

SELECT SCHOOL (S) TO BE PRINTED:

☐ ARTS & SCIENCES

☐ NURSING – Undergraduate

☐ NURSING – Graduate

☐ NEW RESOURCES

☐ GRADUATE/ CO-SPONSORED

DATE OF GRADUATION: _____

DATE OF REQUEST: _____

UID #: _____

DATE OF BIRTH: _____

Did you take courses prior to 1979? (Check one)

☐ YES ☐ NO

Name used while enrolled:

_____

Please indicate if you would like to hold for:

☐ Grades - Semester _____

☐ Degree – Graduation Date _____

Please select:

☐ Student Copy –How many? _____

☐ Official Copy – How many? _____

TOTAL COPIES: _____

Purpose for official transcript:

☐ Educational ☐ Certification

☐ Employment ☐ Other _____

OFFICIAL/STUDENT TRANSCRIPT FEE - $4.00

OFFICE USE ONLY:

Paid: _____ Accepted By: _____ (Initials)

☐ Mailed ____/____/____ by: _____ (Initials)

☐ In-Person ____/____/____ by: _____ (Initials)

☐ In-Per./Mailed ____/____/____ by: _____ (Initials)

White copy: Recipient Yellow copy: File copy Revised: 03/08/13 MJL