

THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER  
Enrollment Management  
2500 North State Street  
Jackson, MS 39216  
(601) 984-1080

## TRANSCRIPT REQUEST FORM

Make copies as necessary for requesting transcripts (1 per page)

Attach a check made payable to the University of Mississippi Medical Center for \$5.00 per transcript requested and mail with this transcript request form to the above address. If paying by visa or master card, complete the credit card information below and mail this transcript request form to the address above, fax it to 601-984-1079, or email it to [transcripts@umc.edu](mailto:transcripts@umc.edu). **Transcripts cannot be faxed.**

Full Name: \_\_\_\_\_

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

Current Telephone # \_\_\_\_\_ Cell Phone # \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Program enrolled in: \_\_\_\_\_ Date entered UMC: \_\_\_\_\_

Current Student \_\_\_\_\_ Former Student \_\_\_\_\_

This is to authorize and request the release of my academic transcript to the person or agency at the address below:

Indicate the number of transcripts to be sent to this address:

\_\_\_\_\_  
Your Signature

\_\_\_\_\_  
Date of Request

Mail Transcript To: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Mail Transcript(s):  Immediately  At end of current term  At end of school year after grades are recorded  After degree is posted

Payment made by:  Check Enclosed  Money Order Enclosed  Credit Card

Credit Card Information: **Visa or Master Card Only**

Name as it appears on the card \_\_\_\_\_

Account Number \_\_\_\_\_

Expiration Date \_\_\_\_\_ Security Code (last 3 digits on back) \_\_\_\_\_