

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 or fax to 601-984-1079. **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) _____