THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
Student Records and Registrar
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 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) _____