

TRANSCRIPT RELEASE FORM-CURRENT STUDENT

CURRENT NAME: _____

NAME AT TIME OF GRADUATION: _____

CURRENT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

SOCIAL SECURITY NUMBER: _____

YEAR OF GRADUATION OR WITHDRAWAL: _____

TRANSCRIPT SHOULD BE SENT TO:

NAME: _____

COMPANY: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

COMMENTS: _____

Please release my transcript to the above-mentioned name.

Signature

Date

SAINT LUKE'S SCHOOL OF RADIOLOGIC TECHNOLOGY
4401 Wornall Road
Kansas City, Missouri 64111
Phone: 816-932-8292 Fax: 816-932-3939
radtech@saint-lukes.org