VANDERBILT UNIVERSITY School of Medicine

Allied Health Program Transcript Request Form

Please print legibly.

Name at time of enrollment: _____
Last First Middle Suffix

Current name (if different from above): _____
Last First Middle Suffix

Date of birth (required): _____ **Dates of enrollment:** _____

Program Attended:
Cardiovascular Perfusion | Diagnostic Medical Sonography | Dietetic Internship
Electroneurodiagnostic Technology | Medical Lab Science | Nuclear Medicine
Radiation Therapy | Other _____

Current address: _____

Phone: _____ **Email:** _____

Signature: _____ **Date:** _____

By federal law, your legal, hand-written signature is required to authorize the release of your transcript.
Hand-writing style fonts or digital signatures will not meet this requirement.

*****Please use a separate form for each recipient.*****

Destination type/Purpose: _____**Self** _____**Agency** _____**Regulatory Board**

_____**Human Resources** _____**College/University** _____**Scholastic Agency**

☐ **Postal Mail (# of copies_____)** **Recipient:** _____

Address 1: _____

Address 2: _____

City/State/Zip: _____

☐ **Pick Up: Eskind Biomedical Library, Suite 224 – Office of Enrollment Services** **(# of copies_____)**
*If you plan to pick up your documents in-office, please bring a form of photo ID.

Submit completed form to:
Vanderbilt University School of Medicine
Office of Enrollment Services
2209 Garland Avenue
Eskind Biomedical Library
Suite 224
Nashville, TN 37240
Fax: 615-343-2312
Email: medverify@vanderbilt.edu
Questions? Please call 615-322-2145