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 _____RegulatoryBoard

_____Human Resources _____College/University _____Scholastic Agency

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

Address 1: _____

Address 2: _____

City/State/Zip: _____

☐ **Pick Up: 303 Light Hall (# of copies_____)**

Submit completed form to:

Office of Enrollment Services
2209 Garland Ave, Suite 224
Nashville, TN 37232

Fax: 615-343-2312

Email: medverify@vanderbilt.edu

Questions? Please call 615-322-2145