

**TRANSCRIPT RELEASE FORM  
RESEARCH MEDICAL CENTER  
SCHOOL OF RADIOLOGIC TECHNOLOGY  
6675 Holmes Rd, Suite 660  
KANSAS CITY MO 64131  
816.276.3390**

**[PLEASE PRINT]**

NAME:

\_\_\_\_\_

Last

\_\_\_\_\_

First

\_\_\_\_\_

Middle

\_\_\_\_\_

Maiden/Other

Current Address:

\_\_\_\_\_

Street

\_\_\_\_\_

City

\_\_\_\_\_

State

\_\_\_\_\_

Zip Code

Phone Number: \_\_\_\_\_

Dates Attended: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Birthdate: \_\_\_\_\_

Request for:

E-Mail Address: \_\_\_\_\_

Official Transcript

Unofficial Transcript

Issue to student

(If requesting an official transcript, it will be in a sealed, signed envelope)

Other (specify) \_\_\_\_\_

**CURRENT STUDENTS ONLY** (please check one):

-Send transcript now

Send transcript after grades are posted (will take a **minimum** of 30 days after end of quarter)

Mail my transcript to:

\_\_\_\_\_  
Name of College/Organization

\_\_\_\_\_  
Attention

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\_\_\_\_\_  
Telephone Number

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

**IN SIGNING THIS FORM, I UNDERSTAND IT WILL TAKE AT LEAST 10 WORKING DAYS FROM THE DATE THE RADIOLOGY SCHOOL RECEIVES THIS REQUEST FOR MY TRANSCRIPT TO BE MAILED OUT.**

Return this form to:  
Research Medical Center  
School of Radiologic Technology  
6675 Holmes Rd, Suite 660  
Kansas City MO 64131

Email this form to Vicki Fayard: [vicki.fayard@hcamidwest.com](mailto:vicki.fayard@hcamidwest.com)

Or Fax it to: 816.276.3388; Attention: Radiology School