

Transcript/Clinical Records Request Form

Student Information

Name: _____ Former/Maiden Name: _____
 Last 4 Digits of Social Security # _____ Date of Birth: _____
 Current Address: _____
 City: _____ State: _____ Zip: _____
 E-Mail: _____ Phone: _____

- Unofficial Transcript number of copies – FREE (*mailed within 3-5 business days*)
 Official Transcript number of copies - \$10.00 per copy / FREE for Current Students (*mailed within 3-5 business days*)
 Expedited Official Transcript number of copies: \$13.00 per copy (*Mailed within 1-2 business days*)
 Copy of Clinical Records (immunization, etc.) - \$10.00 per request / FREE for Current Students (*mailed within 3-5 business days*)
 Clinical Record(s) requested (*List out specific clinical records needed*): _____

1. Transcript/Clinical record requests will not be available until payment is received.
2. All financial obligations must be met before transcripts will be released.
3. Transcripts held for pick-up in the Registrar's/Academic Support Office will be held no longer than 30 days.
4. Unofficial transcripts and copies of clinical records may be faxed or emailed. **Official transcripts will not be faxed or issued by email.**
5. Please make checks or money order payable to Denver College of Nursing and mail with this form or call 303-292-0015 ext. 3620 to pay by credit card or provide the necessary information below.
6. Incomplete forms will not be processed

- Hold for pickup (notification will be sent via email when ready)
 Mail transcript(s)/clinical records to recipient(s) below (List recipient name and address)
 Email/Fax copy of unofficial transcripts/clinical records to recipient(s) below (List recipient name, email or fax number)

Recipient #1

Recipient #2

→ Student Signature: _____ Date: _____ ←
 (*Handwritten signature required for processing)

Mail this form to: Denver College of Nursing, Office of the Registrar, 1401 19th St., Denver, CO 80202
Fax this form to: 720-833-3916 **Email this form to:** AcademicSupport@edaff.com

Official Use Only: Date Request Rec'd: _____ Date Payment Rec'd: _____
 Date Mailed: _____ Mailed by: _____

Major Credit Card Number: _____ Exp. Date: _____
 Cardholder Zip Code: _____ CVC Code: _____ Cardholder Phone: _____
 Name of Cardholder: _____

All credit card information will be redacted once payment has been processed.