



University of TRANSCRIPT REQUEST FORM Saint Mary

Name: _____
Last First Middle Initial

Address: _____
Street City State Zip

Phone: _____ Soc. Sec.#: _____ Date of Birth: _____

Name while attending if different from above: _____

Send to: _____

Reason for having transcript sent: _____

Are you currently enrolled at USM? Yes _____ No _____ Number of transcripts requested _____

Send immediately _____ Hold for semester grades _____ I will pick up on _____

Hold until credits from _____ arrive.
College/University

Credit Card # _____ Expiration Date _____

Signature of Student (Required for Release of Transcript) _____ Date _____

OFFICE OF THE REGISTRAR, 4100 SOUTH 4TH ST TRAFFICWAY, LEAVENWORTH, KS 66048

TRANSCRIPT FEES:

\$1.00 - Currently enrolled USM students

\$5.00 - All other students

FOR OFFICE USE:

_____ Amount Paid
_____ Billed
_____ No. of copies
_____ Date issued
_____ to Student
_____ Date mailed
_____ Person issuing transcript

FAX NUMBER
1-913-758-6218

1-800-752-7043 option 2