

Lourdes Institute of  
Wholistic Studies  
1600 Haddon Avenue  
Camden, NJ 08103

TRANSCRIPT  
REQUEST  
FORM

Lourdes Institute  
Registration Office  
(856) 580-6444  
Fax (856) 580-6448

**Instructions:**

- Please print clearly with pen. Complete all items.** Use a separate form for each addressee. Submit this form to LIWS Registration Office.
- Submit payment of fee** (\$10.00 per recipient address) to the Registration Office. Make check payable to *Our Lady of Lourdes Medical Center*. No transcript request can be honored for a student whose financial obligation to the institute has not been satisfied. Transcript requests will be processed after fee has been received.
- Print student's information** in the box to the **RIGHT**.  
Print clearly. The student's transcript will be sent to the indicated address, and a complimentary copy to the student for their records. →→→
- Print student's social security number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_
- List maiden name or other names used at Lourdes Institute:**  
It is the student's responsibility to notify the recipient of the transcript of the name under which the transcript was recorded. \_\_\_\_\_
- Please sign and date:**  
I request that an official transcript(s) be sent to the address listed to the RIGHT:  
  
Student Signature \_\_\_\_\_  
Date \_\_\_\_\_
- Please print in the box to the RIGHT the exact name and address where the official transcript is to be mailed.** →→→→→→→→→→→→

**INSTITUTE OFFICE USE ONLY**

Date received: \_\_\_\_\_

Date mailed: \_\_\_\_\_

Student's \_\_\_\_\_  
Name      LAST                      FIRST                      MIDDLE

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email Address: \_\_\_\_\_

**RECIPIENT OF TRANSCRIPT:**

Recipient's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Attn: \_\_\_\_\_