



Transcript Request

ALBANY COLLEGE OF PHARMACY AND HEALTH SCIENCES

Phone: 518-694-7222

Fax: 518-694-7093

Please complete this form in its entirety and mail to the address below. Fee: \$5 per Copy (check or money order payable to Albany College of Pharmacy and Health Sciences). Use a separate form for each request, allow one week for processing.

Student: (please print)

_____ Last Name First Name _____

_____ Home Address City State/Prov. ZIP _____

_____ (_____) _____ Degree Received: YES NO
Student ID # or Social Security # Phone Number

_____ Name used while attending ACPHS, if different from above To _____
Date of Attendance

Print exact name and address to which transcript is to be sent:

Number of copies requested: _____ @ \$5 per copy TOTAL: \$_____

Pursuant to provisions of the Federal Family Education Rights and Privacy Act of 1974 (Public Law 93.380), I grant permission to release my academic record to the name/address indicated above.

X _____

SIGNATURE (NOTE: Transcript will not be processed without student signature)

Return to:

**Office of the Registrar
Albany College of Pharmacy and Health Sciences
106 New Scotland Avenue
Albany, NY 12208-3492**