BAPTIST HOSPITALS OF SOUTHEAST TEXAS
SCHOOL OF RADIOLOGIC TECHNOLOGY

REQUEST FOR OFFICIAL TRANSCRIPT

IMPORTANT INFORMATION: Official transcripts will be provided to students upon graduation at no charge. All other request for transcripts will require a $5.00 processing fee.

- Please note: we do not accept phone requests for transcripts. To protect the privacy of student academic records, we require requests to be submitted by fax, by mail, or in person.
- If you have a financial hold on your record, your request will be returned to you.
- To ensure prompt processing, provide all information requested. **Print clearly and in ink.**
- All official transcripts are certified and signed by the Program Director; each is mailed in a separate white sealed envelope. **Do not open the white envelope if you are forwarding to another party (institution, employer, etc.)** Open the envelope only if you have ordered for personal use. **Please note:** Multiple transcripts (each in its own sealed white envelope) sent to a single address will be enclosed in a manila envelope; you may open the manila envelope.
- Allow sufficient time for delivery by U.S. mail; allow up to three weeks for mail delivery to international destinations.
- Requests will not be processed without payment.

Mail request and payment to:
Baptist Radiology School
PO DRAWER 1591
Beaumont, Texas 77704
Request transcripts in person at:
3030 Fannin, Suite A
Beaumont, Texas 77701
(Picture ID is required for in-person requests)
Fax requests to: (409) 212-5743

- Questions? Call (409) 212- 5727 or e-mail robyn.whitney@bhset.net, or deborah.smith@bhset.net

INSTRUCTIONS:

Each numbered instruction corresponds to the numbered item on the form. Please print clearly and in black ink.

1. *Name*—Print your current name and the name(s) you used while you were attending the Radiology School (if different).
2. *Signature*— You ***must*** sign the form. Your request will be returned to you if it is not signed.
3. *Birth date*— This will help us to identify your record.
4. *ID number and SSN*— You only need to include your Social Security number.
5. *Daytime phone number and/or e-mail address*—This information is essential; we may need to contact you with questions that we encounter while processing your request.
6. Indicate the term/years that you attended.
7. On the "Delivery Addresses and Order Detail" page of the form, enter the addresses where you want official transcript(s) to be sent. You ***must*** provide complete mailing addresses or the processing of your request will be delayed.
8. *Order summary*—Indicate the number of transcripts requested on the chart provided. Calculate the total cost of your order. Allow sufficient time for delivery by U.S. mail; allow up to three weeks for mail delivery to international destinations.
9. *Payment method*—if you are faxing this request, you must mail payment to the address provided below. In-person requests may be paid in cash. Checks or money orders must be made payable to the Baptist Hospitals Radiology School.

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REQUEST FOR OFFICIAL TRANSCRIPT

Print clearly and in black ink. Refer to the instruction sheet on the previous page as you fill out the form.

1. Current name
First ______________________ **Middle** ______________________ **Last** ______________________

Name(s) used while attending (if different from current):
First ______________________ **Middle** ______________________ **Last** ______________________

2. Signature (required) ____ **Date** ______________

3. Birth date ______________________ **4. Social Security number** ______________________

Current address: Street ______________________ **City** ______________ **State** ________ **Zip** ________

5. Daytime phone number ______________________ **E-mail address** ______________________

6. Term/year ____________ **to term/year** ____________

7. DELIVERY ADDRESSES AND ORDER DETAIL

Print clearly and in black ink. In the AREA below: **print the names and complete mailing addresses** where you want transcript(s) sent. You ***must*** include a fax number for any fax service request. **Incomplete information will result in a delay in processing your transcripts.**

1. Name of Recipient: ____ **No. of Copies** ________

Address: ____

City: ______________________ **State:** ______________ **Zip Code:** ______________________

***Fax number** ________ - ________ - __________

2. Name of Recipient: ____ **No. of Copies** ________

Address: ____

City: ______________________ **State:** ______________ **Zip Code:** ______________________

***Fax number** ________ - ________ - __________

3. Name of Recipient: ____ **No. of Copies** ________

Address: ____

City: ______________________ **State:** ______________ **Zip Code:** ______________________

Special instructions: ***Fax number** ________ - ________ - __________

8. Payment information (check one): Number of transcripts ________ x $5.00 each =
Amount enclosed

9. ☐ Cash $ ____________
☐ Check or money order payable to the Baptist Hospitals Radiology School $ ____________

OFFICE USE ONLY

Holds: ☐ Yes ☐ No

_____ # Mailed/Faxed; _____ # Given

____
Processed by

Receipting Use Only