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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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

☐ Cash $ __________________
☐ Check or money order payable to the Baptist Hospitals Radiology School $ ______________

OFFICE USE ONLY

Holds: ☐ Yes ☐ No
_______ # Mailed/Faxed; _______ # Given

Receipt Use Only

Processed by