REQUEST FOR SIC TRANSCRIPT

Student Records
3575 College Road
Harrisburg, IL 62946
Telephone (618) 252-5400, ext. 2453
Fax (618) 252-3062

_______________________________ ________________ ________________________________

Social Security Number Student ID Dates of Attendance

_________________ _________________ _______ ____________________

Last Name First Name Initial Previous Name(s)

______________________________ ________________ ________ ______________

Current Address City State Zip

By this signature, I agree to the release of my academic records to the recipient indicated below: _________________________ ____________

Signature Date

Name or Office____

Institution or Business____________________________________

Mailing Address____

City/State/Zip____

Check all that apply:

_____ Hold for ____________ semester's grades

_____ Hold for grade change in _________

_____ Hold for degree/certificate to be posted

_____ Please mail immediately

_____ I will pick up the transcript

Check one: Official Transcript _______ Student Copy _______

How many copies? ________

Please allow at least two business days for processing. Official transcripts are $5.00 each. Student copies are free.

Visa ( ) Mastercard ( ) Discover ( )
Credit Card Number _________________________
Expiration Date _____________________________
Verification # (located on back of card)__________
Amount of Charge ___________________________
Cardholder Phone # __________________________
.

FOR OFFICE USE ONLY
*Request filled by:*________
*Date:*____________________
*Amount paid:*______________