COCHRAN SCHOOL OF NURSING

967 North Broadway
Yonkers, NY 10701

TRANSCRIPT REQUEST FORM

Student's SS#:_____ DOB:_____

First Name:_____ Middle Initial:____ Last Name:_____ Maiden Name:_____

Phone: _____

Graduation Year:_____ Prior to 1999: ☐ YES ☐ NO

Print EXACT Name, Address and Office to which the transcript is to be mailed.

# of copies:_____

Department / Office / Person:

_____

School / Organization:

_____

Address:_____

_____

City, State, Zip:_____

Signature:_____ Date:_____

Fee: $5.00 for each transcript (Payable by money order only). Please include payment with this form.

Mail completed form and payment to:
(Duplicate this form for Additional requests)

Cochran School of Nursing
Registrar's Office
967 North Broadway
Yonkers, NY 10701

Transcript Service Policy

When ordering by mail, **attach a money order** payable to Cochran School of Nursing. Transcript(s) will be sent within 5 business days. Transcripts for pick up by the student will be held for 7 days only. Picture identification will be required to pick up transcripts. All requests must be authorized by the student's signature in accordance with the Federal FERPA Act. Requests by persons other than the student will not be honored without the student's written authorization. Transcripts from other colleges cannot be duplicated. You must contact the college directly for a transcript.

FOR OFFICE USE ONLY: PAID:_____ TOTAL#:_____ DATE PROCESSED:_____