

Request for Transcript

Last Name: _____ First Name: _____

Date of Birth (dd/mm/yy): _____ Year of Graduation from CMCC: _____

Phone #: _____ Email: _____

Current Address: _____

Institution to which you wish your transcript sent:

Name & Title of recipient (e.g. Registrar): _____

Institution: _____

Address: _____

Phone #: _____ Fax #: _____

Fee for an Official Transcript is \$15.00 Canadian (Transcripts Released upon Receipt of Fee)

Cheque enclosed _____ AMEX _____ Visa _____ MasterCard _____

Credit Card Number: _____ Expiry Date: _____ CVV Code: _____

I authorize the Canadian Memorial Chiropractic College to send an official transcript of my academic record at CMCC to the institution at the address noted on this form:

Signature: _____ Date: _____