

Morthland College

Transcript Request Form



Last Name: _____ First Name: _____ Student ID: _____

Date of Birth: _____ / _____ / _____ Today's Date: _____ / _____ / _____
Month Day Year Month Day Year

Dates of Attendance:

Beginning Semester/Year: _____ Ending Semester/Year: _____

Name of College	Address
Transcript 1 <input type="checkbox"/> Pickup at MC <input type="checkbox"/> Mail to:	
Transcript 2 <input type="checkbox"/> Pickup at MC <input type="checkbox"/> Mail to:	
Transcript 3 <input type="checkbox"/> Pickup at MC <input type="checkbox"/> Mail to:	
Transcript 4 <input type="checkbox"/> Pickup at MC <input type="checkbox"/> Mail to:	

Total Number of Transcripts Requested: _____
 \$10 per copy

By my signature below, I signify that I am requesting the stated number of official transcripts to be sent to the stated locations.

Student's Signature: _____ Date: _____ / _____ / _____

**Once completed and signed, return this form with payment to the
 Office of Academic Records, 202 East Main, West Frankfort, Illinois 62896.
 Please allow four (4) weeks for processing.**