



STATE UNIVERSITY OF NEW YORK  
STATE COLLEGE OF OPTOMETRY

## TRANSCRIPT REQUEST

PRINT CLEARLY

FIRST NAME _____ MIDDLE NAME _____
LAST NAME _____
SOCIAL SECURITY NUMBER ____ - ____ - _____
CURRENT ADDRESS _____ _____
CITY _____ STATE _____ ZIP CODE _____

In the space below print full name and address to where transcript is to be sent.

NAME OF RECIPIENT _____
ADDRESS _____ _____
CITY _____ STATE _____ ZIP CODE _____

If attended under any other name, indicate:

FIRST NAME \_\_\_\_\_ MIDDLE NAME \_\_\_\_\_

LAST NAME \_\_\_\_\_

PROGRAM:  O.D.     M.S.     Continuing Education (check one)

TERM AND YEAR OF LAST ATTENDANCE: \_\_\_\_\_ (e.g. Fall, 2005)

NUMBER OF TRANSCRIPTS DESIRED: \_\_\_\_\_

**FEE IS \$5.00 PER TRANSCRIPT. Please pay only by check or money order payable to STATE UNIVERSITY OF NEW YORK.**

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_