Transcript/Clinical Records Request Form

Student Information

Name:_____ Former/Maiden Name: _____
Last 4 Digits of Social Security #_____ Date of Birth: _____
Current Address: _____
City:_____ State:_____ Zip: _____
E-Mail:_____ Phone: _____

[ ] Unofficial Transcript **[ ] number of copies – FREE (*mailed within 3-5 business days*)**
[ ] Official Transcript **[ ] number of copies - $10.00 per copy / FREE for Current Students (*mailed within 3-5 business days*)**
[ ] Expedited Official Transcript **[ ] number of copies: $13.00 per copy *(Mailed within 1-2 business days)***
[ ] Copy of Clinical Records (immunization, etc.) - **$10.00 per request / FREE for Current Students (*mailed within 3-5 business days*)**
Clinical Record(s) requested (*List out specific clinical records needed)*: _____
_____

1. Transcript/Clinical record requests will not be available until payment is received.
2. All financial obligations must be met before transcripts will be released.
3. Transcripts held for pick-up in the Registrar's/Academic Support Office will be held no longer than 30 days.
*4. Unofficial transcripts and copies of clinical records may be faxed or emailed. **Official transcripts will not be faxed or issued by email.***
5. Please make checks or money order payable to Denver College of Nursing and mail with this form or call 303-292-0015 ext. 3620 to pay by credit card or provide the necessary information below.
6. Incomplete forms will not be processed

[ ] Hold for pickup (notification will be sent via email when ready)
[ ] Mail transcript(s)/clinical records to recipient(s) below (List recipient name and address)
[ ] Email/Fax copy of unofficial transcripts/clinical records to recipient(s) below (List recipient name, email or fax number)

Recipient #1 ***Recipient #2***

_____ _____
_____ _____
_____ _____
_____ _____

→Student Signature: _____ **Date:**_____←
(*Handwritten signature required for processing)

Mail this form to: Denver College of Nursing, Office of the Registrar, 1401 19th St., Denver, CO 80202
Fax this form to: 720-833-3916 **Email this form to:** AcademicSupport@edaff.com

Official Use Only: Date Request Rec'd:_____ Date Payment Rec'd: _____
Date Mailed:_____ Mailed by: _____

Major Credit Card Number:_____ Exp. Date: _____
Cardholder Billing Address:_____ CVC Code _____ Cardholder Phone: _____
Name of Cardholder: _____

All credit card information will be redacted once payment has been processed.

REV. 12/08; 01/11; 08/12,8/18; 03/27/19