**REQUEST FOR TRANSCRIPT**

School Name When Attended:

_______ Centra College

_______ Lynchburg General Hospital School of Nursing

_______ Centra Health School of Practical Nursing

_______ Virginia Baptist Hospital School of Nursing

_______ # of Unofficial Requested

_______ # of Official Requested

Current Name: ______________________________________________________________

Name when enrolled: __________________________________________________________

Last 4 of SS Number : ______________________________ D.O.B: __________________

Phone Number: _______________________ Email: ____________________________________

Program of Study: _____________________ Year of Graduation: ______________________

Name and Address/Email where you would like transcript/s sent (Please specify difference in official/unofficial if applicable):

(1) ____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

(2) ____________________________________________________________

____________________________________________________________

____________________________________________________________

____________________________________________________________

**FEE: $5.00 per copy – No cash accepted**
**Email or Mail form with fee to the following address:**
Attn: Kendra Damore
Registrar
Centra College
905 Lakeside Drive, Suite A
Lynchburg, VA 24501
Registrar@centracollege.edu
*__Please note__: Transcript requests will be processed in **5-7** business days.

__________________________ __________________________________________
Date Signature