REQUEST FOR TRANSCRIPT

_____ Centra College of Nursing

_____ Lynchburg General Hospital School of Nursing

_____ Centra Health School of Practical Nursing

_____ Virginia Baptist Hospital School of Nursing

Current Name:_____

Name when enrolled:_____

Social Security Number:_____ D.O.B._____

Date of Graduation or years of attendance:_____

_____ # of Unofficial Requested _____ # of Official Requested

Name and Address where you would like transcript/s sent:

(1) _____

_____

_____

(2) _____

_____

_____

FEE: $5.00 per copy (no charge to currently enrolled students)
Mail transcript form with fee to the following address:

Centra College of Nursing
905 Lakeside Drive, Suite A,
Lynchburg, VA 24501

_____ _____

Date Signature