MOREHOUSE SCHOOL OF MEDICINE

Transcript Request Form

Name: _____ Date: _____

Student ID #: _____ Email or Phone: _____

Type of Transcript

☐ Official ☐ Unofficial

# of Copies

_____

Select the Method of Delivery

☐ **Student Pick-up** ☐ **Campus Mail Box** ☐ **US Mail** (Please print the complete address below)

_____

_____

_____

_____

(**Please allow 5 Business days for processing**)

Student Signature: _____

Morehouse School of Medicine – Office of the Registrar – 720 Westview Drive, Atlanta, GA 30310
(404) 752-1658 (P) & (404) 752-8686 (F)