

**INSTRUCTIONS FOR FILLING OUT THE
TRANSCRIPT – DEAN’S LETTER
REQUEST FORM**

Please print out the **Transcript – Dean’s Letter Request Form** and fill in the appropriate boxes.

| | |
|-------------------------------|--|
| DATE OF REQUEST | Enter date you are filling out form. |
| MATRICULATION DATE | Enter date you started medical school. |
| DATE OF GRADUATION | Enter date you received your medical degree. |
| GRADUATE NAME/ADDRESS | Type or print your name and present address. |
| STUDENT SIGNATURE | Please sign your name – DO NOT TYPE OR PRINT NAME. |
| SOCIAL SECURITY NUMBER | Enter your Social Security Number. |
| DATE OF BIRTH | Enter your birth date. |
| MAIDEN OR OTHER NAME | If name in Graduate Name box is different than the name you received your MD degree under, please type or print Maiden or Other Name. |
| TELEPHONE NUMBER | Enter your daytime telephone number. |
| NUMBER OF COPIES | Please check whether you are requesting an OFFICIAL or UNOFFICIAL TRANSCRIPT and/or DEAN’S LETTER. Type or print in the number of copies you are requesting of each. |
| SEND TRANSCRIPTS TO | Type or print the name and address where you would like the transcript and/or Dean’s Letter to be sent. |
| SPECIAL INSTRUCTIONS | Type or print any special instructions regarding this request. |

Once you have filled out the Transcript – Dean’s Letter Request Form, please mail to the following address:

**Heather C. Davison
Registrar, School of Medicine
Virginia Commonwealth University
1101 East Marshall Street
P. O. Box 980565
Richmond, VA 23298-0565**

If you are requesting transcripts, please enclose a check made payable to **VCU SCHOOL OF MEDICINE**. The fee is \$5.00 per transcript (CHECKS ONLY).

Due to the transcript fee requirement, we cannot accept requests for transcripts by telephone, fax or e-mail.

**VIRGINIA COMMONWEALTH UNIVERSITY
SCHOOL OF MEDICINE
REGISTRAR'S OFFICE**

**TRANSCRIPT – DEAN'S LETTER REQUEST FORM
(\$5.00 Per Transcript)**

Date of Request:

Matriculation Date:

Date of Graduation:

**GRADUATE
NAME AND ADDRESS:** (please print clearly)

**I authorize the release of my academic records
to the individual(s) named in this request.**

Student Signature (do not print)

Social Security Number:

Date of Birth:

Maiden or Other Name:

Telephone Number:

Number of Copies: (check appropriate boxes and indicate number)

- | | | |
|--|-----|--------------------------|
| <input type="checkbox"/> Official | NO. | <input type="checkbox"/> |
| <input type="checkbox"/> Unofficial | NO. | <input type="checkbox"/> |
| <input type="checkbox"/> Dean's Letter | NO. | <input type="checkbox"/> |

Send Transcripts to:

NAME AND ADDRESS (please print clearly)

SPECIAL INSTRUCTIONS:

OFFICE USE ONLY

Information Received By: _____

Date Request Picked Up: _____

Date Request Sent: _____