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:

Registrar, School of Medicine
Virginia Commonwealth University
1201 East Marshall Street
PO 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)

____

Send Transcripts to:

NAME AND ADDRESS (please print clearly)

____

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____

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

____
Student Signature (do not print)

last 4 digits

Social Security Number: XXX-XX-

Date of Birth: ____________

Maiden or Other Name: ____________

Telephone Number: ____________

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

- ☐ Official NO. ☐
- ☐ Unofficial NO. ☐
- ☐ Dean's Letter NO. ☐

SPECIAL INSTRUCTIONS:

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OFFICE USE ONLY

Information Received By: ____________________

Date Request Picked Up: ____________

Date Request Sent: ____________