

**University of Connecticut School of Medicine, and Dental Medicine
Office of the Registrar
263 Farmington Avenue
Farmington, CT 06030-1827**

Forms are to be submitted by fax to 860- 679-1902 or by mail to the above address. Requests can also be submitted by e-mail to registrar@uchc.edu

Please print all information clearly and completely.

Student's Name (Last, First, MI) _____

Date of birth ____/____/____

School (Medical/Dental) and Year of Graduation _____

If you have ever attended the University of Connecticut under other names, please indicate them here:

Student's permanent home address

Street _____

City _____ State _____ Zip _____

Please indicate a phone number (with area code) or an e-mail address at which you may be reached should it be necessary for us to call you about this request. Phone: _____

E-mail: _____

Dates of attendance at the University of Connecticut

First semester attended _____ Last semester attended _____

I hereby authorize the University of Connecticut to release my official transcripts to the recipients named on this form.

Date ____/____/____ Signature _____

There is no fee for transcript requests.

**Please Send Official Transcripts of my Academic Record to the following recipients
Please print all information clearly and completely.**

Recipient #1

Number of transcripts _____

