COLLEGE OF
MOUNT SAINT VINCENT

OFFICIAL TRANSCRIPT REQUEST FORM

Please mail the request with check payment to:

College of Mount Saint Vincent
Registrar's Office, Attn: Transcript Specialist
6301 Riverdale Avenue, NY 10471

Student Information

Name: _____ Student ID#: _____
Last (Maiden) First Middle

Address: _____ Telephone#: _____
Street Number City or Town State, Zip Code

Dates of Attendance: _____ Degree Received: _____

Date of Graduation: _____

Type of Transcript: ☐ **Official** ☐ **Student** **Type of Record:** ☐ **Undergraduate** ☐ **Graduate**

FEES PER TRANSCRIPT:

☐ **$5.00 for up to 10 business day process**

SEND TRANSCRIPT TO:

_____
Name

_____
Street Address

_____
City or Town State Zip Code

Student's Signature: _____ Date: _____

If this form is not signed by the student, the request will not be granted.

- Full name of student (indicate maiden name or name as it appears on school records if applicable), current address, telephone number, and dates of attendance.
- Indicate the month and year of graduation or withdrawal.

PLEASE NOTE: TRANSCRIPTS WILL NOT BE RELEASED IF THERE IS AN OUTSTANDING BALANCE ON YOUR ACCOUNT OR ANY OTHER HOLDS.