

Belize Medical College
CAHSH



TRANSCRIPT REQUEST FORM

Transcripts are **\$30.00** each official or unofficial. Requests will be honored **only** if all financial obligations are cleared.

Student Name: _____
Last First Middle

Student Address: _____
Current Address

City State Zip Code

Student Phone # _____

Social Security # or I. D. # _____

*Please allow 1-2 weeks
for transcript preparation*

Date of Birth: _____

First Trimester Attended: _____

Enter number of copies requested: _____

Pick-up _____ or To be mailed _____ (Check one)

If mailed, please fill out address you want transcript to be sent to:

_____	Delivery Method: Regular/ Priority/ Express Mail (Please Circle One)
Company or Recipient Name	

Mailing Address	

City State Zip Code	

Please Fax this form to: 575-589-4860