



MedStar Health

**MedStar Washington Hospital Center Medical Imaging School
of Radiology
Official Transcript Request Form**

REQUEST FROM: (Name, Last 4 of SSN #, Year of Graduation and Address)

TRANSCRIPT REQUEST MUST BE SIGNED BY THE STUDENT

I, _____, give MedStar Washington Hospital Center Medical Imaging School of Radiology permission to send ____ copies of my official transcript to the name and address identified below.

Thank you

Signature

Date

WHERE TRANSCRIPTS SHOULD BE SENT **IF TRANSCRIPTS ARE BEING SENT TO THE STUDENT PLEASE PUT YOUR CONTACT INFORMATION HERE

(Name and Address)

