

RELEASE OF ACADEMIC RECORD

MedCentral College of Nursing • 335 Glessner Avenue • Mansfield, OH 44903 • fax: 419.520.2638

Student Information:

Name: _____	Soc. Security #: _____
Previous Name: _____	Last Year Attended: _____
Address: _____	Phone: _____
City: _____	State: _____ Zip: _____

Academic Record(s) to release:

_____ Copy of Immunization Record (\$2.00)

_____ Documentation of student enrollment status

_____ Letter of Recommendation (letter may include, but not limited to, grades, gpa, class rank)

From (person writing the letter): _____

Purpose of letter: _____

Student MUST check the following statement for Letter of Recommendation:

I waive do not waive my right to review a copy of this letter at any time in the future.

_____ Official Transcript (3 Complimentary transcripts per year, \$5.00 per transcript after that)

_____ Other: Please list _____

(There is a \$2.00 Administrative fee for all "other" copies)

Release to (complete this section for letters of recommendation also):

Name of Institution: _____
Name of person: _____
Address: _____
City: _____ State: _____ Zip: _____

Signature & Date:

Signature: _____ Date: _____

Please enclose the fee, if applicable, in cash or a check payable to MedCentral College of Nursing

Office official only:

Processed by:

Date:

Payment received: