

# TRANSCRIPT REQUEST FORM

## OFFICE OF THE UNIVERSITY REGISTRAR

### SECTION I: Student Information

Date:  Network ID:  Last 4 of SSN:

Name:  Date of Birth:   
(Last) (First) (Middle) (mm/dd/yyyy)

Email Address:  Daytime Phone #:

Current Address:   
(Street) (City) (State) (Zip)

**\*\*\*Signature\*\*\***

Form must be signed by the student in order to be processed.  
(Signing another person's name constitutes fraud.)

Other name(s) while at CWRU:

First attended : Semester Year Last attended : Semester Year

Please list all CWRU schools attended (e.g. undergrad, medicine):

Please list any degree(s) and year(s) received:

### SECTION II: Delivery Method

**Please indicate the number of transcripts to be sent :**

By Fax :   
\$10 Per Copy (Quantity)

By Mail :   
\$5 Per Copy (Quantity)

Attn:

Fax #:

Mailing Addresses:

Please include a typed page with additional addresses, if needed.  
No need to include another transcript request form.

Would you like delivery via FedEx for an additional \$21 per address?  Yes  
(FedEx cannot deliver to a PO Box)

### SECTION III: Transcript Request

**Issue transcript :**  As Is

**-or-**

**Hold transcript for:**

(Please note - we cannot hold a request for more than 30 days)

Current semester grades

Degree posting of :   
(Month/Year)

### SECTION IV: Payment Information

**Please select method of payment:**

Check/Money Order  
(Payable to: Case Western Reserve University)

Credit Card Select Card Type:  MasterCard  Visa  Discover Total Amount:

Name of Cardholder:  Signature of Cardholder: \_\_\_\_\_

Billing Address:   
Street City State Zip

Credit Card Number :  Expiration Date:   CCV #:   
(Year) (3 digits on back of card)

### SECTION V: Submission

Please print and sign, then fax or mail this form. (Processing time is 1-3 business days)

**Office of the University Registrar**  
Yost Hall Room 135  
10900 Euclid Avenue  
Cleveland, OH 44106-7042  
Phone (216) 368-4310  
Fax (216) 368-8711



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