ALBANY COLLEGE OF PHARMACY
AND HEALTH SCIENCES

Transcript Request

Phone: 518-694-7222 Fax: 518-694-7400

Please complete this form in its entirety and mail to the address below. Fee: $5 per Copy (check or money order payable to Albany College of Pharmacy and Health Sciences). Use a separate form for each request, allow one week for processing.

Student: (please print)

_____ _____
Last Name First Name

_____ _____ _____ _____
Home Address City State/Prov. ZIP

_____ (____) _____-_____ Degree Received: ☐ YES ☐ NO
ID # Phone Number

_____ _____to_____
Name used while attending ACPHS, if different from above Date of Attendance

Print exact name and address to which transcript is to be sent:

_____

_____

_____

_____

Number of copies requested: _____ @ $5 per copy TOTAL: $_____

Pursuant to provisions of the Federal Family Education Rights and Privacy Act of 1974 (Public Law 93.380), I grant permission to release my academic record to the name/address indicated above.

X _____ _____
SIGNATURE (NOTE: Transcript will not be processed without student signature) DATE

Return to:

Office of the Registrar
Albany College of Pharmacy and Health Sciences
106 New Scotland Avenue
Albany, NY 12208-3492