James H. Quillen College of Medicine

Office of the Registrar
Transcript Request Form

Please print this form; fill it out completely, including your signature, then fax or mail per instructions below.

Last Name	First Name	Middle Name	Maiden Name
Name on medical school record if different than above		Last year of attendance	Date of Birth
Current Street Address		Current Daytime Phone Number	Number of Transcripts Needed
City	State	Zip	
Signature to request transcript(s) **X**		Date	

MAIL TO (Leave this section blank if you wish to pick up your transcript):

Name (Person)			You may **FAX** this form to **(423) 439-2110** or mail it to: **James H. Quillen College of Medicine** **Office of the Registrar** **PO Box 70580** **Johnson City, TN 37614**
Name (Business or Institution)			
Street Address			
City	State	Zip	

Name (Person)		
Name (Business or Institution)		
Street Address		
City	State	Zip