



**\*Note to Applicant - This form should be submitted directly to your school.  
Please do not return to Galen.**

### College Transcript Request Form

Name (printed) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone (include area code) \_\_\_\_\_ Cell Phone (include area code) \_\_\_\_\_

Institution Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (include area code) \_\_\_\_\_

From: \_\_\_\_\_

Name (please print)

Social Security Number

I attended \_\_\_\_\_ from

Institution Name

\_\_\_\_\_ to \_\_\_\_\_ I graduated \_\_\_\_\_

start date

end date

if applicable

I authorize the Registrar to release information concerning my academic record (grades, courses, dates attended and honors) to:

Galen College of Nursing  
1031 Zorn Avenue, Suite 400  
Louisville, KY 40207  
502.410.6200

Signature: \_\_\_\_\_

Date: \_\_\_\_\_