**Transcript Request Form**

Office of Records & Registration

 2400 Tom L Wilson Blvd. Galesburg, IL 61401
 Phone: 309-341-5237
 Fax: 309-344-3291
Email: transcripts@sandburg.edu

**Last Name:**
**First Name:**
**Maiden Name:**
**Birthdate:**
**Last 4 of SS# or Sandburg ID:**
**Todays Date:**
**Current Phone Number:**
**Current Mailing Address:**

**Please update my address and/or phone number:**

**Number of copies requested:**

**Email address for electronic delivery only:**

**Send Transcript To:**

\_\_\_\_\_\_Please send transcripts now

\_\_\_\_\_\_When Grades are Posted

\_\_\_\_\_\_When Degree/Certificate is Posted

\_\_\_\_\_\_Pick up transcript now

\_\_\_\_\_\_Please check here only if you were a student before 1985

Note: THE COLLEGE MAY CONTACT YOU TO VERIFY MAILING ADDRESS OF RECIPIENT

**REQUESTOR’S SIGNATURE:**

I authorize Carl Sandburg College to release my academic transcript to the institution or person(s) above.

**Financial obligations to the college must be satisfied before a transcript will be issued. Transcripts are normally processed within 1 to 2 business days. Please allow two (2) weeks at the end of the term for a transcript to be sent. Transcripts will be sent electronically whenever possible through Parchment® to in-network recipients.**

**------------------------------------------------------------------For office use only-------------------------------------------------------------------------**

**Transcript was sent:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mailed: Faxed:**

**Processed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**  **Parchment: Picked up:**