Mary Lanning
HEALTHCARE

School of Radiologic Technology
Request for Transcript

Print Name _____ _____ _____ _____
Last First Middle Former name

Address _____ _____ _____ _____
Street City NE Zip

Number of transcripts needed _____ (Please include $5 for each transcript.)

Signature _____ Date _____

Phone _____ SSN# XXX-XX-_____ Birth date _____

Special instructions _____

_____

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Mail transcripts to (Official transcripts, those bearing a raised seal, may only be sent to a college/business. Unofficial transcripts may be sent to the individual.) _____

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This information is provided with the understanding that the recipient, if other than the student, will not disclose the information to any other party without prior consent of the student as required by the Family Education Rights and Privacy Act of 1974.

Please make check payable to: Mary Lanning Healthcare
Mail to: Education Department
Mary Lanning Healthcare
715 N. St. Joseph Ave.
Hastings, NE 68901