Radiation Sciences Education

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TRANSCRIPT REQUEST FORM

STUDENT INFORMATION:

Current Full Name _____ Former Name(s) (if applicable) _____

Current Residing (Billing) Address _____ City _____ State _____ Zip _____

UID or HAWKID (if known) _____ Date of Birth _____ Cell or Daytime Phone _____

Current Email Address: _____

Are you currently enrolled at the University of Iowa? YES NO

PROGRAM INFORMATION:

Program(s) completed at UI:

- ☐ Radiologic Technology
  - Graduation Date: _____
- ☐ Diagnostic Medical Sonography
  - Graduation Date: _____
- ☐ Radiation Therapy
  - Graduation Date: _____
- ☐ Nuclear Medicine Technology
  - Graduation Date: _____
- ☐ Bachelor of Science in Radiation Sciences
  - Graduation Date: _____
- ☐ Bachelor of Science in Nuclear Medicine Technology
  - Graduation Date: _____

TRANSCRIPT INFORMATION: *(only UIHC program transcripts will be sent; request official UI transcripts here)*

Send transcript via (select one):

- ☐ Email: _____
- ☐ US Mail: _____
  Name

  _____
  Street Address City State Zip

SIGNATURE AND DATE:

- ☐ I acknowledge that a confidential document will be delivered to the email or US mail indicated above.
- ☐ I attest that all information is accurate and give my permission to release the records indicated above.

_____ _____
Signature – **REQUIRED** for release of records. A typed name will **NOT** be accepted. Date
This form must be printed, scanned, and emailed to: laurie-calkins@uiowa.edu