CVPH School of Radiologic Technology
75 Beekman Street
Plattsburgh, NY 12901
Ph 518-562-7510 fax 518-562-7486

Request for Transcript

Student Name _____

Student Name at graduation (if different) _____

Year of Graduation _____

Is this an Official Transcript _____

Name and Address to be sent to

_____

_____

_____

I authorize the School of Radiology at CVPH Medical Center to send my transcript to the above person or institution.

Student signature _____

Date _____

completed form can be sent electronically to mgarcia@cvph.org