

Sovah - School of Health Profession's Nursing Program

(Formerly: Danville Regional Medical Center)

Transcript Request

142 S Main Street, Danville, VA 24541

Phone: (434)-799-4443 Fax: (434)799-3718

Please allow 7-10 days for processing.

Student Name: _____

Last name at time of graduation (**if different from above**): _____

Last Date Attended: _____ Class of: _____ DOB: _____

Phone #: _____

Address: _____

Street

City

State

Zip

Total # copies requested: _____ # Official Copies: _____ # Unofficial copies _____

Fee: \$10.00 per transcript Total amount to complete request \$_____

Pick up or Email to _____

Fax _____ **Name of business or contact person** _____ **Fax #** _____

Mail to _____ **Name of business or contact person** _____ **Phone #** _____

Address: _____
Street _____ City _____ State _____ Zip _____

Please make checks payable to: Sovah - School of Health Professions

Charge Card Request by Phone:

I approve Sovah- School of Health Professions to charge my account in the amount of \$ _____.

Master Card
 Discover

Visa
 American Express

Card # _____

Expiration Date _____

V-Code (3 digit #) _____

Note: Failure by the student to pay proper financial obligations may result in the withholding of official transcripts. In accordance with the Family Educational Rights and Privacy Act of 1974. The attached record is being released with the consent of the student. This authorization does not permit you to transmit this information to other individuals, agencies or organizations other than yourself and in order to do so, you must secure the written consent of the student.

Signature _____

Date _____

For School Use:

Picked up Faxed Mailed Date ____/____/______ Total Fee Paid \$_____

Request Completed By: _____