CENTRA COLLEGE

REQUEST FOR TRANSCRIPT

School Name When Attended:

_____ Centra College

_____ Lynchburg General Hospital School of Nursing

_____ Centra Health School of Practical Nursing

_____ Virginia Baptist Hospital School of Nursing

_____ # of Unofficial Requested

_____ # of Official Requested

Current Name: _____

Name when enrolled: _____

Last 4 of SS Number : _____ D.O.B: _____

Phone Number: _____ Email: _____

Program of Study: _____ Year of Graduation: _____

Name and Address/Email where you would like transcript/s sent (Please specify difference in official/unofficial if applicable):

(1) _____

_____

_____

_____

(2) _____

_____

_____

_____

FEE: $5.00 per copy – No cash accepted
Email or Mail form with fee to the following address:

Attn: Kendra Damore
Registrar
Centra College
905 Lakeside Drive, Suite A
Lynchburg, VA 24501
Registrar@centracollege.edu

*__Please note__: Transcript requests will be processed in **5-7** business days.

_____ Date

_____ Signature