UK College of Dentistry-Transcript Request Form

University of Kentucky College of Dentistry
Office of Admissions and Student Affairs
800 Rose Street, Room M-134
Lexington, KY 40536-0297
Fax 859-257-5550, Office 859-323-6071
Registrar Email: mlock2@email.uky.edu

Please complete the following form and mail, fax or e-mail. There is no charge for transcripts.

Today’s Date: ______________________________

STUDENT INFORMATION

Year of Graduation: ______________________________
First Name: ______________________________
Middle Name: ______________________________
Last Name: ______________________________
Maiden/Other Name: ______________________________
(Only if enrolled under this name while at UKCD)
Street 1: ______________________________
Street 2: ______________________________
City/State: ______________________________
Zip/Postal Code: ______________________________
Phone: ______________________________
Last 4 of SSN: ______________________________

Please mail transcript to:

Name/Company: ______________________________
Attention: ______________________________
Street 1: ______________________________
Street 2: ______________________________
City/State: ______________________________
Zip/Postal Code: ______________________________

NOTE: IF YOU ARE REQUESTING MULTIPLE COPIES, PLEASE SUBMIT A FORM FOR EACH REQUEST.

Signature of Student/Graduate: ______________________________

By signing, I authorize the Office of Admissions and Student Affairs to release my official transcript to the above named individual or company.