AUGUSTANA COLLEGE

TRANSCRIPT REQUEST

2001 S Summit Avenue
Sioux Falls SD 57197
605-274-4121 - Office
605-274-4450 - Fax

NAME: _____ **DATE:** _____
First Middle Last

FORMER NAMES: _____

SS #: _____ - _____ - _____ **OR** **ID #:** _____

BIRTHDAY: _____/_____/_____

CURRENT ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

PHONE NUMBER: _____

Number of copies to be mailed _____ picked up _____

Please send my transcript to:

_____

_____

_____

_____

Please fax/email my transcript to:

_____

_____

_____

_____

* Additional addresses can be written on the back of this form

Signature _____
* REQUIRED *

NOTE: Augustana College will not release transcripts until all accounts, including load funds administered by the college, are paid in full or are current according to established repayment schedules

☐ Send transcript now

☐ Hold for degree ☐ Hold for final Fall/Interim/Spring/Summer grades

☐ Hold for grade (list titles of workshops)

_____

_____

Signature of Business office (if required): _____