



Immunization Transcript Request

Mail, FAX or bring completed form with payment to:

Mail Health Services-- SCCC, 112 College Road, Loch Sheldrake, NY 12759-5151
FAX 1-845-434-3628
Phone 1-845-434-5750 Ext. 4 247

Allow at least 5 business days for processing. During busy periods it may take slightly longer. Transcripts are not sent if records are impounded.

Student Information - Please PRINT

Name: _____
 First *Middle Initial* *Last*

If attended SCCCC with a different name, provide name: _____

Street/Apartment: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Business/Cell Phone: _____ Date of Birth: _____

Order Information

_____ at \$10 each. Total payment \$_____ Last 4 digits of Social Security #: _____
of transcripts

Signature: _____ Date: _____

____ Mail to self - address above ____ Fax to # below
____ Mail to address(s) listed below

1. Name of Institution: _____
Office or Contact Person: _____
Street: _____
City: _____ State: _____ ZIP: _____
Fax #: _____

Payment Method

____ Cash ____ Cash/Money Order (Payable to "SCCC")
____ Credit Card () Discover Card () Master Card () Visa () American Express

Print name as it appears on credit card: _____
If credit card billing address is different than the student making request, provide complete address:

Credit Card #: _____
Expiration Date: ____/____/____ Three digit code on back of card: _____

authorize transcript fees listed

(above to be charged to my credit card. Signature: _____ Date: _____

Office Use Only
Received by: _____
Date Received: _____
Fee Paid: \$ _____
Date Mailed: _____