Student Health Services
112 College Road
Loch Sheldrake, NY 12759
(845) 434-5750 ext. 4247
Fax: (845) 434-3628
Email: Healthservices@sunysullivan.edu

Immunization Transcript Request

- **Mail, Fax or bring this completed form with payment to the Health Services Office.**
- **Allow at least 5 business days for processing. During busy periods it may take slightly longer. Immunizations will not be sent if there is a hold/impound on them.**

Student Information – Please PRINT

Name:_____
First Middle Initial/Name Last

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

Mailing Address: _____

City:_____ State: _____ Zip: _____

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

Order Information:

of Transcripts Requested _____ x $10 each = Total Payment: $_____

Signature: _____ **Date:** _____

Please check one:

_____ Mail to self – (address above)
_____ Mail to address listed below
_____ Pick Up by self
_____ Fax to number below

Name of Institution or Place to be sent: _____

Contact Person (if applicable): _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Fax #: _____

Payment Information (If billing address is different than above, please include it on here)

____ Cash _____ Check/Money Order (Made payable to SUNY Sullivan)

_____Credit Card (_) Discover (_) Master Card (_) Visa (_) American Express

Print Name as it appears on credit card: _____

Credit Card #:___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

Expiration Date: ___ ___ /___ ___ Three digit code on back of card: ___ ___ ___

I 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:_____

Revised 4/24/18 lg