TRANSCRIPT REQUEST

Name: ______________________ **I.D./S.S. No.** ______________

Mailing Address: ______________________________________
(Street address, P.O. Box, Rural Route, Etc.)

____
(City) (State) (Zip) (County)

Contact Phone Number: ______________

Former Last Name(s): ______________________________________

Dates Attended: ______________ **Major:** ______________

Signature: ______________________ **Date:** ______________

Federal law requires student's signature before a transcript can be released.

Number of transcripts requested: ________
(limit of 5 per request)

Degree or Certificate Will Be Completed This Semester

- **Yes**
- **No**

Requested Method: (Transcripts cannot be sent by email or fax.)

- **Mail**
- **Will pick up**
- **SPEEDE (to other institutions in Arkansas)**
- **PDF (only to ADHE)**

Hold until grades are posted:

- Spring
- Intersession
- Summer I
- Summer II
- Fall

List Name(s) and Address(es) of Individual/College/University Where Transcript(s) Should Be Mailed:

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Note: Transcripts of student's records will not be released until all financial and/or administrative obligations to the college have been satisfied.

OFFICE USE ONLY

ID Verified: ______________ **Date Issued/Mailed/Speede:** ______________

Processed By: ______________

Rev: 04/28/2022

REGISTRAR'S OFFICE

1537 University Boulevard, Morrilton, AR 72110 | (501) 977-2052 | 1-800-264-1094 | Fax: (501) 354-7566 | registrar@uaccm.edu