## TRANSCRIPT RELEASE FORM-FORMER STUDENT

CURRENT NAME:		
NAME AT TIME OF GRADUA	TION:	
CURRENT ADDRESS:		
CITY:	STATE:	ZIP:
PHONE NUMBER:		
SOCIAL SECURITY NUMBER	:	
YEAR OF GRADUATION OR	WITHDRAWL:	
TRANSCRIPT SHOULD BE S	SENT TO:	
NAME:		
COMPANY:		
ADDRESS:		
CITY:	STATE:	ZIP:
Please release my transcript to the	ne above-mentioned name. I realize t quest is processed. Please make checl	hat a \$5.00 fee must be
Signature		

Saint Luke's Hospital
Attn: School of Diagnostic Medical Sonography
901 E 104<sup>th</sup> St.
Mailstop 3000 South
Kansas City, Missouri 64131
Phone: 816-932-2788 Fax: 816-932-2815