THE UNIVERSITY OF MISSISSIPPI MEDICAL CENTER
Student Records and Registrar
2500 North State Street
Jackson, MS 39216
(601) 984-1080

TRANSCRIPT REQUEST FORM

Make copies as necessary for requesting transcripts (1 per page)

Attach a check made payable to The University of Mississippi for $5.00 per transcript requested and mail with this transcript request form to the above address. If paying by visa or master card, complete the credit card information below and mail this transcript request form to the address above or fax to 601-984-1079. **Transcripts cannot be faxed.**

Full Name:____

Current Address:____

Current Telephone #___________________________ Cell Phone #_______________________________

Social Security Number:____

Program enrolled in:___________________ Date entered UMC:_________________

Current Student_____________ Former Student_____________

This is to authorize and request the release of my academic transcript to the person or agency at the address below:

Indicate the number of transcripts to be sent to this address: ☐

_______________________________ Your Signature

__________________________ Date of Request

Mail Transcript To: ____

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Payment made by: ☐ Check Enclosed ☐ Money Order Enclosed ☐ Credit Card

Credit Card Information: **Visa or Master Card Only**

Name as it appears on the card____

Account Number____

Expiration Date________________________Security Code (last 3 digits on back)_____________