Cleveland Institute of Dental-Medical Assistants, Inc.

"Professionals training Professionals"

2450 Prospect Avenue 2nd floor ● Cleveland, OH 44115 ● 216-241-2930
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Student Transcript Request

Please Read! There is a **$5.00 fee for each transcript.** Please complete the form below. Make sure you print clearly and give a contact number where you can be reached. If you are requesting multiple copies, please make sure you include mailing instructions for each. All transcripts are sealed documents that must be in a sealed envelope when being mailed to other schools or business unless intended for personal use.

Date Requested: _____ Number of copies requested _____

Student Name: _____ Social Security Number: _____-___-_____
(Please use name attended under and print clearly)

Address: _____ Phone Number: (____) _____-_____

City: _____ State: ___ Zip: _____ Alternate Number: (____) _____-_____

Program: _____ Start Date: _____ Grad ( ) Yes ( ) No Grad Date: _____

Please convert ____ (one) or ____ (each) transcript from clock hours to credit hours.

Provide forwarding address(s) if different than above:

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For Office Use Only: *Amount Received: $_____ *Method of Payment ____ Cash ____ Money Order
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