Transcript Request Form

THIS FORM IS FOR THE LONDON CAMPUS ALUMNI ONLY

A charge of $25.00 is payable for each transcript

If you have an outstanding account, no transcript will be sent

Fax this completed form to (519) 659-2516

_____ _____

Student's Last Name First Name

Previous Name(s) (While at Medix College)

_____ _____

Student ID Number

Date of Birth

_____

Dates of Attendance (from – to)

Graduated: ☐ Yes ☐ No

_____ _____

Current Address

Phone Number

_____ _____

Email

For immediate notification of transcript processing, please provide an email address

Program Attended

Please forward _____ copy/copies of my transcript to:

_____

_____

_____

_____ _____

Student's Signature

Date

Payment

☐ VISA ☐ MasterCard

Credit Card Number _____

CV2 Number: _____ This is the 3 digit number located on the back of your VISA or MasterCard

Expiration Date: _____

Cardholder's Billing Address: _____