UNIVERSITY OF CENTRAL FLORIDA
College of Medicine

M. D. Transcript Request Form

College of Medicine Registrar's Office

6850 Lake Nona Blvd., Suite 115
Orlando, FL 32827-7408
Phone: (407) 266-1371
Fax: (407) 266-1389

- **The University WILL NOT provide an official transcript to any student or alumnus who has not met his or her financial obligations to UCF.**
- **Photo I.D. must be presented at pick-up.**
- **Transcripts will not be e-mailed or faxed to recipients.**
- **Transcripts not claimed within 30 days of printing will be discarded and must be reordered.**

TYPE OR PRINT LEGIBLY OR TRANSCRIPT PROCESSING WILL BE DELAYED

PID OR SSN: ☐ ________

Name:

____

Last Name **First Name** **Middle Name** **Maiden/Previous**

Birth Date: ____ /_____/_____ **Email: _________________________________** **Daytime Phone #:_______________**

Your Current Mailing Address:

☐ Number of transcripts to be sent to me at this address

☐ **I will pick up my transcripts**
Number of transcripts to be picked up

Street ____

City, State, Zip ____

3rd Party Pick up (if applicable): ____

I authorize the person named as 3rd party to pick up my transcripts (The designee above must present photo I.D.)

Send Transcripts to Address Listed Below: (*List additional addresses on separate sheet if necessary*)
The College of Medicine Registrar's Office is not responsible for an incorrect address that you provide. It is your responsibility to check the address for accuracy. If it is incorrect and cannot be delivered, any returned transcript will be destroyed.

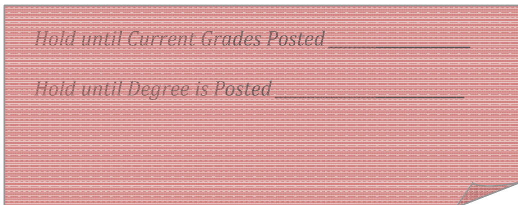
☐ Number of transcripts to be sent to this address

Name ____

Address ____

City, State, Zip ____

For Office Use Only!



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SIGNATURE **DATE**