OFFICE OF THE REGISTRAR - TRANSCRIPT REQUEST FORM

Please read the policy before you print out, complete, and mail this form with payment, if applicable to:
The New England College of Optometry, Registrar's Office, 424 Beacon Street, Boston, MA 02115

Name: _____
Last First Middle

Last 4 digits of Social Security # _____ Date of Birth: _____

NECO Degree(s) received with graduation date(s) or dates of attendance: _____

Present Address: _____

_____ E-mail: _____

Telephone Day: _____ Evening: _____

Three to five working days are required for all transcripts. No transcripts will be sent until all outstanding fees have been paid.

There is a charge of $10.00 per transcript (official or unofficial) for alumna/alumnus. The correct amount must accompany this request. Official transcripts are not sent to alumna, alumnus or students.

Please INDICATE number of transcript(s) and PRINT name and address of where to be sent.

1. Circle the number of transcripts to be sent to the address below in the same envelope: **1 2 3**

_____
_____
_____
_____

2. Circle the number of transcripts to be sent to the address below in the same envelope: **1 2 3**

_____
_____
_____
_____

3. Circle the number of transcripts to be sent to the address below in the same envelope: **1 2 3**

_____
_____
_____
_____

4. Circle the number of transcripts to be sent to the address below in the same envelope: **1 2 3**

_____
_____
_____
_____

Signature: _____ **Date:** _____

FOR OFFICE USE ONLY

Amount received: _____ Check____/Cash_____ Received by: _____

Date Sent: _____ Sent by: _____