

**STUDENT TRANSCRIPT REQUEST FORM**

Student Name: \_\_\_\_\_

Maiden Name (if applicable) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

School Attended: \_\_\_\_\_

Year of Graduation: \_\_\_\_\_

Send Transcript to: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Student's Current Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Phone#: \_\_\_\_\_

I authorize the Catholic Education Center to release a copy of my school transcript:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

- There is a \$5.00 fee per copy of transcript (payable to the Catholic Education Center)

Please mail form and fee to:

Catholic Education Center  
4445 Lindell Blvd.  
Saint Louis, MO 63108  
Attn: Colleen Martin