



# Transcript Request Form

Cloud County Community College  
Office of Student Records  
PO Box 1002  
Concordia, KS 66901-1002  
(785) 243-1435 or 800-729-5101  
FAX: (785) 243-9380  
studentrecords@cloud.edu

Please print all requested information.

Name: \_\_\_\_\_  
Last First Middle Maiden/Other Names

SSN or College ID# \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Current Address: \_\_\_\_\_  
Street City State Zip

Daytime Phone Number: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_

Currently enrolled  Yes  No If no, last date attended CCCC \_\_\_\_\_

\_\_\_\_\_ Number of transcripts requested

Send transcript:  Send now, do not hold for semester grades  
 Send at end of current semester  
 Hold until degree is posted

Any additional instructions:

The appropriate fee must accompany any request or the request will not be processed. Please allow up to 5 working days, upon receipt, for processing, **or two weeks for those sent at the end of the current semester or posting of degree.** Requests will be withheld from any student who owes the College money or property. Transcripts are released only by a request signed by the student. Official transcripts given to the student are stamped "Issued to Student." Some institutions will not accept such transcripts. It is your responsibility to check with that school.

<p><b>TRANSCRIPT MAILING INFORMATION:</b></p> <p>_____</p> <p>Name of School or Business</p> <p>_____</p> <p>Name of Person or Department</p> <p>_____</p> <p>Street</p> <p>_____</p> <p>City, State Zip</p>	<p><b>If by E-Mail or FAX, complete the following: (all faxed transcripts are marked unofficial)</b></p> <p><b>Place/Person:</b></p> <p>_____</p> <p><b>E-Mail:</b></p> <p>_____</p> <p><b>FAX Number (area code first):</b></p> <p>_____</p>
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Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**Processing fee for each official transcript is \$5.00. No charge for unofficial transcripts.**

Total Amount Being Paid: \_\_\_\_\_

Payment Enclosed (check one)  Check (# \_\_\_\_\_)  Cash  Money Order

**OR**

Credit Card Information:  Visa  Mastercard  Discover

Card # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ 3 digit code on back of card \_\_\_\_\_

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

Name on card \_\_\_\_\_

Billing address of cardholder \_\_\_\_\_  
Street City State Zip

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**For Office Use Only:** Date Transcript Was Sent: \_\_\_\_\_ Student Records Initials \_\_\_\_\_