LOGAN UNIVERSITY

Request for Academic Transcript

Please mail this request to: Office of the Registrar, Logan University, Chesterfield, MO 63017
Fax: (636) 207-2431 or Email: registrar@logan.edu

Last Name: ________________________ First Name: ______________________ MI/Maiden: _____________________

Name on Record: _______________________________________ Date of Birth: ___________________________

Current Address: ____

Phone #: _______________________________________ Email: _______________________________________

Graduation Date (if applicable): __________________________________

Mark Applicable Degrees: Doctor of Chiropractic _____ Master of Science _______ Bachelor of Science _________

Send Transcripts (check one): Now: ___________ After grades are posted: _____ After graduation is posted: __________

_____ Quantity for **pick-up**: indicate the number of transcripts you will pick-up in person

_____ Quantity for **mail**: indicate how many transcripts to mail to address below

Name: ____

Street Address: ____

City: _____________________________ State: ______________ Zip: _______________

Payment should be made by check, cash, money order or credit card (Visa, MasterCard or Discover only). You may also call (636) 230-1739 with your payment information. Transcripts will be sent via U.S. mail. Transcripts may also be picked up in person at the Office of the Registrar.

FOR OFFICE USE

Fee _________________

Date _________________

Sent __________________

Credit Card #: ________________________________ Expiration Date: _____

A charge of $5 is assessed for each transcript issued.

I hereby authorize Logan University to release my transcript of academic records to the above named institution or individual.

Signature: ____ Date: ______________