

STOCKTON UNIVERSITY OFFICIAL TRANSCRIPT REQUEST

OFFICE OF THE REGISTRAR – REGISTRAR@STOCKTON.EDU
101 VERA KING FARRIS DRIVE, CAMPUS CENTER 203, GALLOWAY, NJ 08205-9441
FAX 609-626-5547

PLEASE PRINT CLEARLY. Before making an official transcript request verify your unofficial transcript to ensure that all information is correct and has been posted (i.e., degree(s), grades, honors, program distinction, etc.)

Z number: _____ **or** Social Security Number (Last 4 digits only): _____

First Name: _____ Last Name: _____ MI: _____

Former Name (If applicable): _____

Address: _____
Street City State Zip Code

Telephone: _____ Cell: _____

Email: _____

PLEASE CHECK ALL THAT ARE APPLICABLE

Current Student Former Student Attended prior to 1989

TOTAL NUMBER OF COPIES _____

- SEND WITHIN 3-5 BUSINESS DAYS- SENT STANDARD MAILING ONLY - NO CHARGE
 URGENT REQUEST-PLEASE SEND IMMEDIATELY- \$10 PER COPY (IN PERSON PICK-UP ONLY)
 CHECK HERE IF ADDITIONAL ADDRESSES ARE LISTED ON SECOND PAGE OF THIS FORM

MAIL TO (Include name of person, school name, agency, business, department, address, to the attention of, etc.)

Location 1:

Location 2:

I hereby certify that this information is true and correct. As per the Federal Family Education Rights and Privacy Act (PL 93:360), I authorize the release of my academic record.

Signature: _____ Date: _____

FOR OFFICIAL USE ONLY

BURSAR: # of copies _____ PAYMENT RECEIVED _____ DATE _____ INITIALS _____