Ohio Valley Hospital School of Radiography
Transcript Release Form

In compliance with the Family Education Rights and Privacy Act (FERPA), no information regarding a student may be released without proper authorization. You must complete the following application before your transcript may be released.

Please type or print the following information:

Date	
Full Name (First/Middle/Last)	
Previous Name If Applicable	
Address	
Phone	
SSN	
Date of Birth	
Dates Attended	From: To:
Graduation Year	
Send Transcript To:	

Please sign below.

Signature

Return this form to:

Ohio Valley Hospital
School of Radiography
25 Heckel Road
McKees Rocks, PA 15136-1694

*** Requests will be granted within five (5) business days of date received ***
Please include a $5.00 administrative fee for request of an official transcript.
Make checks payable to **Ohio Valley Hospital School of Radiography**.