



AMERICAN INSTITUTE OF MEDICAL TECHNOLOGY

Official Transcript Request

Current Name: _____ Previous Name: _____

SSN #: _____ DOB: _____

Phone: () _____ - _____

Student Mailing Address: _____

Program(s): _____ Program Start Year _____

Check only one per request:

Please mail _____ copies of my transcript to my mailing address listed above.

Please mail _____ copies of my transcript to the name and address below:

Mail to: _____

Third party authorization: (good for one use only)

Please allow (name of party) _____ to pick up _____ sealed copies of my transcript.

Student Signature: _____ Date: _____

Return this form in person, mail, fax or email

When returning by fax or if mailed please include legible copy of valid driver's license

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Fax 918-496-8505

Email Jennifer.brooks@aimt.edu