

TRANSCRIPT REQUEST FORM

St. Clairsville High School
102 Woodrow Avenue
Saint Clairsville, OH 43950
Phone: 740-695-1584 / Fax: 740-695-2513

Name at Graduation//Withdrawal _____

Last Name (Current) _____ First Name _____

Year of Graduation _____ Date of Withdrawal _____ Date of Birth _____

Current Address _____

City _____ State _____ Zip Code _____

Telephone Number _____ Cellular _____

Email Address _____

SIGNATURE _____ **DATE** _____

Recipient _____

College/Technical School/University/Employer/Personal

Address _____

City _____ State _____ Zip Code _____

Note any special instructions:

\$2.00 payment received by: _____ initials

Date transcript mailed _____ by: _____ initials

Date transcript given to student _____ by: _____ initials