WILSON COLLEGE

TRANSCRIPT REQUEST AUTHORIZATION

Department of Nursing
1015 Philadelphia Avenue, Chambersburg, Pa. 17201
717-262-4853 | WWW.WILSON.EDU/NURSING

TRANSCRIPT INFORMATION (Please print in ink)

To: Registrar _____
(Name of College/University)

_____
(Address)

From: Nursing Department
Wilson College
1015 Philadelphia Avenue
Chambersburg, Pa. 17201

PERSONAL INFORMATION

Name _____ Home phone: (_____) _____
(First) (MI) (Last)

Address _____ Cell phone: (_____) _____
(Street)

_____ Work phone: (_____) _____
(City) (State) (Zip code)

Email: _____

Please list all previous names that may be reflected on your transcripts: _____

Birth date: _____ / _____ / _____ Social Security Number: _____

PRIOR STUDENT INFORMATION

Name while in attendance if other than above: _____

I attended your college/university from: _____ to _____

AUTHORIZATION

I, _____ , grant the Wilson College Department of
(Print Name)

Nursing permission to receive an official copy of my transcripts from your institution.

Signature of Applicant: _____ Date: _____