



REQUEST FOR TRANSCRIPT

HSD LVN/CNA Medical Assistant or Other _____

In order to be of service to you in processing your transcript quickly and accurately, please complete all the following information clearly. Processing may take up to ten days. Email form to Registrar at: susana.rivera@oxnardunion.org

YOU MUST PRESENT A VALID PHOTO ID AT THE TIME OF SUBMITTING YOUR REQUEST

PERSONAL INFORMATION	
Name _____	_____
last	first middle maiden
Social Security #: _____	Birthdate: _____ Phone #: _____
Last day attended school: _____	Date of HIGH SCHOOL graduation _____

TRANSCRIPT DELIVERY	
Please check ONE of the following options for delivering your transcripts:	
Pick up: <input type="checkbox"/> I will pick up	<input type="checkbox"/> Someone will pick up for me
Number of copies): _____	
NAME OF DESIGNATED PERSON (photo ID will be required) _____	
Mail: <input type="checkbox"/> Mail the official copy (copies) of my transcript to: (ATTACH COPY OF PHOTO ID TO THIS REQUEST)	_____

Signature: _____ Date: _____

CREDIT PAYMENT FOR DUPLICATE CERTIFICATE (CTE CLASSES ONLY)	
<input type="checkbox"/> Visa <input type="checkbox"/> Master Card	Credit Card #: _____
Expiration date: Month _____ Year _____	V-Code _____
Name as it appears on card: _____	
Mailing address: _____	
Amount: \$10.00 (per certificate) Number of Certificates: _____ Signature: _____	

FOR OFFICE USE ONLY	
Order received by: _____	Date sent or picked up: _____
Pick up signature: _____	
Payment: \$ _____	Receipt: _____ <input type="checkbox"/> Cash <input type="checkbox"/> Credit <input type="checkbox"/> Check # _____ <input type="checkbox"/> Money order # _____