MARCELLUS
Senior High School

ALUMNI TRANSCRIPT REQUEST FORM

Send to:
Marcellus High School Counseling Office
1 Mustang Hill
Marcellus, NY 13108
dgascon@marcellusschools.org
Fax: 315-673-6327

Student Name _____ Date of Birth: _____

Full Name While Attending MHS (if different) _____

Year of Graduation or Withdrawal _____

Address _____
Street *City* *State* *Zip*

Phone # _____ Email Address: _____

☐ **Pick-Up**

☐ **E-Mail Recipient Address:** _____

☐ **Mail:**

NAME OF THE RECIPIENT(S) AND MAILING ADDRESS(ES)
You are responsible for the correct, complete, and legible address.

Recipient #1	**Recipient #2**
Name/School _____	Name/School _____
Company/Office _____	Company/Office _____
Address _____	Address _____
_____	_____
City, State, Zip _____	City, State, Zip _____

If you have additional recipients, please attach another form.

I, the above-named student, certify that all the information provided is correct; that the recipient(s) information is accurate, complete, and legible. I understand that the transcript will be provided in a stamped and sealed envelope to the recipients listed (transcripts mailed to graduates are unofficial and will not be stamped and sealed), and that tampering with the envelope will nullify the validity of the transcript(s).

Alumni Signature _____ Date _____