Baystate Medical Center

Baystate Medical Center School of Nursing Transcript Request Form

This form is for all former Springfield Hospital/Baystate Medical Center nursing students requesting an official or unofficial copy of her or his transcript.

I am requesting that my academic record (transcript) be sent from Baystate Medical Center to the address given below and I understand that this request serves as an official release authorization.

__________________________________ Requestor Signature

________________ Date

PERSONAL DATA				
Student's Name: Last, First				
Student's Maiden Name (*if applicable*):				
Current Mailing Address:				
City:		State:		ZIP Code:
Home Phone:	Cell Phone:		E-mail:	
SCHOOL OF NURSING ACADEMIC INFORMATION				
Years Attended:				
Graduation Date:				
TRANSCRIPT INFORMATION				
No. of Official Transcript (*$2.00 per copy, if more than 5*):				
No. of Student Copies *(no charge):*				
Address of institution(s) or home address where transcript should be sent:				

1.	**2.**	**3.**
Official Copy Student Copy	Official Copy Student Copy	Official Copy Student Copy

PLEASE RETURN THE COMPLETED FORM TO:

Healthcare Education Office
c/o Graduate Medical Education
Baystate Medical Center, Inc.
3601 Main Street, 3rd Floor
Springfield, MA 01199
EMAIL: gme@baystatehealth.org
FAX: 413-794-0300

(PLEASE NOTE: Requests will be processed within 7 working days of receipt of this form)