Transcript Request Form for the College of Medicine
Please print Legibly.

Name Last _____ First _____ Middle In. _____

Address _____

City _____ State _____ Zip Code _____

Email _____ Phone _____

Former Last Name _____

Date _____ Social Security number _____

Mail to: _____

Address _____

_____

City _____ State _____ Zip Code _____

Please check one:

Graduate ☐ Year _____ Withdrew ☐ Current student ☐

Other ☐ Please explain _____

Student Signature: _____

In accordance with Federal Laws and KRS 164.283, records cannot be released with out written consent of the student.

Note: **Transcript will not be released if the student has an outstanding financial obligation to the University of Kentucky College of Medicine.**

Please mail, email, or fax this form to:
University of Kentucky College of Medicine
800 Rose Street, MN-104
Lexington, KY 40536-0298
Phone 859-323-5261
Fax 859-323-4094
med.registrar@uky.edu