Tufts UNIVERSITY | School of Dental Medicine

Transcript Request Form

Please complete this form to request a Dental School transcript. There is a $5 fee per official transcript requested. You may deliver your completed transcript request form to the Dental Student Affairs Office on the 15th floor of 1 Kneeland Street, fax it to 617-636-0309 or mail it to:

Tufts University
Registrar's Office
Attn: Genevieve Olivera
1 Kneeland Street
Boston, MA 02111

Please note: If this form is sent via fax, a transcript will not be ordered until a check has arrived in the mail.

First name ________________________________ Last name __________________________________

E-mail Address____

Former name, if any, during enrollment ____

Dates of attendance _______________________________

Degree awarded __________________________________

Home address ____
street apt. #

____
city state zip code country (if not U.S.)

Telephone # _____________________________________

Please send _____ copies to the address below (if home address, leave blank).

Delivery Method (check one)

- ☐ Send transcript directly to the organization listed below.
- ☐ Place transcript in a sealed envelope and mail it to me. (If the envelope is opened before it reaches the organization, it is not considered official.)
- ☐ Place transcript in a sealed envelope for me to pick up in the Student Services Office.

Name of Organization ____

Address ____

____

____
city state zip code country (if not U.S.)

I authorize the issuance of my transcript as indicated on this form.

Signature ____ Date _________________________