Transcript Request Form

Please note that academic records, which include, but are not limited to, academic transcripts, certification of enrollment, degree and graduation date, may be withheld from any party requesting this information should the student or graduate be in default of a student loan or owe a balance to the university.

By registering for classes with Tufts Dental School, students accept and agree to be bound by the above policy as applied to any preexisting or future obligation to the University.

Please complete this form to request an official transcript. There is no charge for processing transcript requests. You may deliver your completed transcript request form to the Office of the Registrar on the 15th Floor of the Dental School, fax it to 617-636-4088, scan and email it to dental_registrar@tufts.edu or mail it to:

Tufts University School of Dental Medicine
Office of the Registrar
1 Kneeland Street
15th Floor
Boston, MA 02111

First Name ______________________________ Last Name ______________________________

E-mail Address ______________________________ Dates of attendance ______________________________

Degree(s) 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 from the Office of the Registrar.

Name of Organization ______________________________

Address ____
street apt. #

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

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

Signature______________________________ Date ______________________________