

**ARMSTRONG COUNTY MEMORIAL HOSPITAL
SCHOOL OF RADIOLOGIC TECHNOLOGY
ONE NOLTE DRIVE
KITTANNING PA 16201
724-543-8206**

**TRANSCRIPT REQUEST – Form #35
\$5.00 PROCESSING FEE
MAKE CHECK OR MONEY ORDER PAYABLE TO ACMH**

Social Security _____

Number of copies required _____

Former Name (if applicable) _____

Years attended _____

Student's Name and Address

Signature _____

Date of Request _____

Mail Transcript to:

OFFICE USE ONLY

FEE PAID \$ _____

DATE MAILED _____

Official transcripts will be sent by mail only to potential employers, other schools or agencies at the direction of the requestor. All transcripts ISSUED TO THE STUDENT will not bear the institutional seal, and will be marked **ISSUED TO STUDENT**.

