

GRADUATE NAME (PRINT – Last, First, Middle Initial)	DATE OF GRADUATION
CURRENT NAME - <i>if different from the above</i> (PRINT – Last, First, Middle Initial)	

I request **1 unofficial copy** of my transcript be sent to me.

MAILING ADDRESS	CITY	STATE	ZIP
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**OR**

I request **1 official copy** of my transcript be sent to:

NAME OF INSTITUTION	ATTENTION TO		
MAILING ADDRESS OF INSTITUTION	CITY	STATE	ZIP

Graduate / Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please mail or fax the completed Transcript Request to:

**Regional Health Rapid City Hospital**  
Medical Imaging Manager  
PO Box 6000  
Rapid City, SD 57709-6000

**OR**

Fax Number: (605) 755-1436