MONUMENT HEALTH

Medical Radiography Program Transcript Request

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

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

MAILING ADDRESS	CITY	STATE	ZIP

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:_____ **Print to Sign** _____Date: _____

Please mail or fax the completed Transcript Request to:

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

OR

Fax Number: (605) 755-1436