



## Transcript Request

Office of Records and Registration  
St. Cloud Technical College  
1540 Northway Drive  
St. Cloud, MN 56303  
Phone 320 308-5075 FAX: 320 308-5909

Last Name \_\_\_\_\_

First Name \_\_\_\_\_

Student ID # or SSN# \_\_\_\_\_

Phone Number \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Circle one:    Currently Enrolled    Graduate    Withdrawal

Print name & address of where you wish transcript sent:

Date/Year of attendance: \_\_\_\_\_

\_\_\_\_\_

Program you were in: \_\_\_\_\_

\_\_\_\_\_

Maiden name if applicable: \_\_\_\_\_

\_\_\_\_\_

Send now     I will pick up on \_\_\_\_\_

Send after grades are posted     Send after degree is posted

Student Signature and Date: \_\_\_\_\_

Paid \_\_\_\_\_ Rec'd \_\_\_\_\_ Sent \_\_\_\_\_

There is a \$7.00 charge for each transcript, payable at the time requested. Make checks payable to SCTC. Requests for transcripts will be processed within five working days of receipt of request.