Transcript Request Form

SUBMIT TO: Attn: LHCA Registrar
(800) 951-3757 fax
admissions@larockacademy.com

(Check One)

- ☐ Larock Healthcare Academy 3260 W Henderson Rd, Suite 20, Columbus, OH 43220
- ☐ Larock Healthcare Academy 61 W. Aurora Rd., Northfield, OH 44067
- ☐ Larock Healthcare Academy 4960 Higbee Ave., N.W., Suite 200, Canton, OH 44718
- ☐ Larock Healthcare Academy 10 Spiral Drive, Florence, KY 41042

FROM: _____
(Name of student) PLEASE PRINT

SUBJECT: Transcript Request *(mark one)*

☐ Official Transcript
☐ Unofficial Transcript

Please send my transcript to:

_____

_____

_____

_____

_____

Student Information:

Social Security Number: _____

Name While Enrolled: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____

Phone Number: _____

Please mark your selection:

☐ Regular Transcript Request (sent within 3-5 business days): $6.00
☐ Expedited Transcript Request (sent within 2 business days): $10.00

_____ _____
SIGNATURE: DATE: