

LINDENWOOD

LINDENWOOD UNIVERSITY ST. CHARLES, MISSOURI

Transcript Request

I, the undersigned, do hereby authorize the release of my school/college transcript and request that an office copy be sent to:

Lindenwood University
ATTN: Evening and Graduate Admissions
209 South Kingshighway
St. Charles, MO 63301-1695

Name of School/College: _____ City/ State _____

Date of Graduation: _____

Name of Student: _____

Current Name: _____

Social Security Number: _____ DOB: _____

Signature: _____ Date: _____

Registrar: Please attach this request form to transcript before mailing to Lindenwood University.

Counselor

OFFICE USE ONLY	
Check payable:	
Fee:	Address:

If there is a problem in processing this request, please contact:

Betty Taylor (636) 949-4643 or Btaylor@lindenwood.edu