Stony Brook
School *of* Dental Medicine

OFFICIAL TRANSCRIPT REQUEST

For School of Dental Medicine Students / Graduates Only

1. Stony Brook ID ____ ____ ____ ____ ____ ____ ____ ____ ____ 2. Today's Date: _____

3. Student Name (please print or type): _____
   Last First M.I.

4. Daytime phone number: (___) _____ 5. Year Graduated: _____

6. Email: _____

7. Student Signature **(required to authorize release of transcript)**: _____

REQUEST IN PERSON: Bring this completed form and a check for the total amount of requested transcripts to the School of Dental Medicine, Office of Education, 115B Rockland Hall.

REQUEST BY MAIL: Mail this completed form and a check for the total amount of requested transcript to Stony Brook University, School of Dental Medicine, 115B Rockland Hall, Stony Brook, NY 11794-8709.

If you are not a student or graduate of the School of Dental Medicine you must order your official transcripts by contacting either the Registrar's Office for undergraduate and graduate transcripts http://www.stonybrook.edu/registrar/transcripts.shtml or the School of Medicine at (631) 444-2341.

Attachments to be mailed with transcripts may be sent along with this form by mail, faxed to (631) 632-7130, or provided in person. Please contact the Office of Education at (631) 632-5468 with any questions you may have regarding transcript requests.

Make checks payable to SUNY at Stony Brook.

7. Please enter the address(es) where you would like your transcript sent and the service level requested:

You must provide a complete address including zip code to ensure that your transcript is deliverable.

Request # 1: Number of transcripts to be sent to this address: _____

Regular Mail ($10 fee per transcript) ☐ Express ($30 fee per transcript) ☐

Name: _____

Address: _____

_____

_____

City: _____ State: _____ Zip: _____

Special Instructions (attachments, etc.): _____

Request # 2: Number of transcripts to be sent to this address: _____

Regular Mail ($10 fee per transcript) ☐ Express ($30 fee per transcript) ☐

Name: _____

Address: _____

_____

_____

City: _____ State: _____ Zip: _____

Special Instructions (attachments, etc.): _____

Request # 3: Number of transcripts to be sent to this address: _____

Regular Mail ($10 fee per transcript) ☐ Express ($30 fee per transcript) ☐

Name: _____

Address: _____

_____

_____

City: _____ State: _____ Zip: _____

Special Instructions (attachments, etc.): _____

Request # 4: Number of transcripts to be sent to this address: _____

Regular Mail ($10 fee per transcript) ☐ Express ($30 fee per transcript) ☐

Name: _____

Address: _____

_____

_____

City: _____ State: _____ Zip: _____

Special Instructions (attachments, etc.): _____