School of Radiologic Technology
RELEASE OF INFORMATION REQUEST

Please complete all information and return via email (PDF), regular mail, or Fax to 609-599-5529.

STUDENT NAME (last, first, m): ____

NAME AT GRADUATION (if different):_____________________________________

ADDRESS: ____

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PHONE: ________________________ FAX: ________________________

GRADUATION YEAR:_________________ Last 4 digits of SS #:_________________

Please release the item(s) checked to the party indicated below:

- ☐ Official Copy of the School of Radiologic Technology Transcript (NOTE: Official copy cannot be released to student.) *Transcripts from other schools you have attended must be requested from the original school.*
- ☐ Verification of Enrollment Status
- ☐ Verification of Expected Graduation
- ☐ Letter of Recommendation from (indicate name):_____________________________
- ☐ Other (please indicate):____

INFORMATION RELEASED To (required):

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SIGNATURE:____________________________________

DATE:________________

- -

OFFICIAL USE ONLY

DATE SENT:________________________ COMPLETED BY: ________________________

COMMENTS:

Revised December 2022