

Please print this transcript request form, complete, and mail, e-mail or fax it to us.

Please mail request with the \$5 fee per transcript to:

Office of the Registrar
Campus Box 145
Knox College
2 East South Street
Galesburg, IL 61401

You can also fax your request with a billing address to:

(309) 341-7601

**Or, you can e-mail this document as an attached PDF (including your signature) to:
registrar@knox.edu**

PERSONAL INFORMATION AND BILLING ADDRESS

Student ID Number (if known): _____ Phone Number: (____) _____ - _____

Student Name (Please Print):

Street: _____

City: _____ State: _____

Zip: _____

Country: _____

Last Year Attended: _____

PURPOSE OF TRANSCRIPT

Please check:

_____ Grad School (field: _____)

_____ Medical School, Dental School

_____ Fellowship, Scholarship

_____ Transfer

_____ Off-Campus Study (Program: _____)

_____ Military Service

_____ Peace Corps

_____ Teaching Certificate

_____ Job Application

_____ Other

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Please send my transcript(s) to the following addresses:

1) _____

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AUTHORIZATION

I authorize Knox College to release my Knox College Transcript to the parties named on this form.

SIGNATURE: _____

Date: _____