Aurora St. Luke's Medical Center
School of Radiologic Technology

Transcript Release

Name _____ Date _____

Current Mailing Address _____

City _____ State _____ Zip _____

I. SCHOOL INFORMATION

Start Date _____ End Date _____

(month/year) (month/year)

School Attended

- ☐ Deaconess Hospital
- ☐ Family Hospital
- ☐ Good Samaritan Medical Center
- ☐ Lutheran Hospital
- ☐ Milwaukee Hospital
- ☐ Mount Sinai Hospital
- ☐ St. Luke's Medical Center

II. STUDENT INFORMATION

Social Security #	Date of Birth	Maiden Name

III. RECIPIENT INFORMATION

Name: _____

Organization: _____

Address: _____

_____

_____

☐ I authorize St. Luke's Medical Center School of Radiologic Technology to forward a copy of my official transcript to the aforementioned institution/individual.

☐ Copy of transcript issued to student/graduate.

_____
Student Signature

_____ _____
Faculty Signature Date of Record Release

Fax request to: (414) 747-4366

Mail Requests to: School of Radiologic Technology
AHC – Airport
180 W. Grange Ave.
Milwaukee, WI 53207