KNOX COLLEGE

OFFICE OF THE REGISTRAR

PAPER TRANSCRIPT ORDER FORM

Please complete this transcript request form, and either mail, or fax, or scan and e-mail it to us as below. ***We must have your signature on the form.***

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 (including your signature and a billing address) to:
(309) 341-7601

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

PERSONAL INFORMATION AND BILLING ADDRESS

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

Date of Birth (MM/DD/YYYY) _____

Legal Name While Attending (Please Print): _____

Current Legal Name (if different): _____

City: _____ State:_____

Zip: _____

Country: _____

Last Year Attended: _____

PURPOSE OF TRANSCRIPT Please check:

_____Grad School (field:_____)
_____Medical School, Dental School
_____Off-Campus Study (name of program:_____)
_____Fellowship, Scholarship
_____Military Service
_____Teaching Certificate
_____Other
_____Transfer
_____Peace Corps
_____Job Application

SEND TRANSCRIPTS TO THE FOLLOWING ADDRESSES

1) _____

_____

_____

_____

Number of Copies: _____

2) _____

_____

_____

_____

Number of Copies: _____

AUTHORIZATION

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

SIGNATURE: _____

DATE: _____