Transcript Request Form

Please PRINT Clearly
Name(s) while a student

(Last Name) (First Name) (Middle Name)

Current Name (If different)

(Last Name) (First Name) (Middle Name)

Current Address ______________________________________________________________

Phone Number __________________ Year of Graduation_________ Date of Birth __________

Email Address _______________________________________________________________

Name, specific office and address where transcript is to be sent: (Complete mailing address required)

1. __________________________________________________________________________
   __________________________________________________________________________

2. __________________________________________________________________________
   __________________________________________________________________________

__________________________________________________________
Signature Required

__________________________________________________________
Date

Fax completed form to:
LSWHs Registrar Office
Fax: 816-986-4116

Mail Complete form to:
LSWHs Registrar Office
2600 SW Ward Rd
Lee's Summit, MO 64081

Email completed form to:
Carrie.Guittar@lsr7.net