

Alexandria School of Scientific Therapeutics

Alexandria



Indiana

PO Box 287 / 809 S. Harrison St., Alexandria, IN 46001

Phone: (765) 724-9152

Official Transcript Request Form

STUDENT INFORMATION

Full Legal Name: _____

Last

First

Middle

Name used while attending school: _____

Home Address: _____

City: _____ State: _____ Zip: _____ County: _____

Birth Date: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Is this transcript request for the Licensing Application? Yes No

Website for Professional Licensing Agency (to download instructions & application): <http://www.in.gov/pla/massage.htm>

Graduate Signature: _____ Date: _____

Starting January 1, 2010 the following fees apply:

\$5.00 per transcript OR

\$10.00 to fax transcript OR

\$11.00 to send certified mail (NCBTMB)

Mail completed form & correct fee/money to address listed above

TO SEND TO A LOCATION OTHER THAN YOUR HOME

I hereby request and authorize you to forward my official transcript to a location other than my home:

Attention: _____

Business/School: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

INFORMATION FOR REFERRALS ONLY:

I give permission for my name and phone number to be released to individuals who may be looking for a massage therapist in my area.

Phone number to be used for referral: _____

I give permission for my name and phone number to be released to prospective students that may call me and ask me questions pertaining to the school and my training.

Phone number to be used for referral: _____

I understand that I may request in writing at any time for this information to be removed from the above listings.

I do not wish to have my name, phone number, fax number and email address used for any referral or referral material.