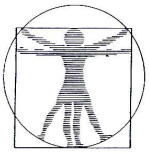
Alexandria School of Scientific Therapeutics

Alexandria  Indiana

PO Box 287 / 809 S. Harrison St.
Alexandria, IN 46001
Phone: (765) 724-9152

Mail completed form & correct fee/money to school address listed above Attn: Transcript

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: _____

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

Graduate Signature: _____Date:_____

The following fees apply per transcript:
$5.00 to mail or pick up (to individuals)
$13.00 to MBLEX as of (January 1, 2019)
$13.00 to send certified mail (all state boards request must go Certified or Professional Licensing Agency)

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:

☐ 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.