TRANSCRIPT REQUEST

REGISTRAR'S OFFICE

1537 University blvd.
Morrilton, AR 72110

(501) 977-2052
1-800-264-1094
Fax: (501) 354-7566

registrar@uaccm.edu

Name: _____ **I.D./S.S. No.** _____

Mailing Address: _____
(Street address, P.O. Box, Rural Route, Etc.)

_____
(City) (State) (Zip) (County)

Contact Phone Number: _____

Former Last Name(s): _____

Dates Attended: _____ **Major:** _____

Signature: _____ **Date:** _____

Federal law requires student's signature before a transcript can be released.

Number of transcripts requested: _____
(limit of 5 per request)

Degree or Certificate Will Be Completed This Semester

- ☐ **Yes**
- ☐ **No**

Requested Method: (Transcripts cannot be sent by email or fax.)

- ☐ **Mail**
- ☐ **Will pick up**
- ☐ **PDF (only to ADHE)**
- ☐ **Hold until grades are posted:**
  - ☐ **Spring**
  - ☐ **Intersession**
  - ☐ **Summer I**
  - ☐ **Summer II**
  - ☐ **Fall**

List Name(s) and Address(es) of Individual/College/University Where Transcript(s) Should Be Mailed:

_____

_____

_____

_____

_____

_____

Note: Transcripts of student's records will not be released until all financial and/or administrative obligations to the college have been satisfied.

OFFICE USE ONLY

ID Verified: _____ **Date Issued/Mailed/Speede:** _____

Processed By: _____