



American Institute of Alternative Medicine Transcript Request Form

The transcript fee (subject to change) is \$10.00 per copy and **must** accompany this request.
All transcripts sent via U.S. Mail. Call 614-310-0173 for special handling (additional fees may apply).

Please submit the completed form along with payment to:

Office of the Registrar
6685 Doubletree Avenue
Columbus, Ohio 43229

Student Information

_____-_____-_____ Social Security Number		_____ Class Of
_____ Last	_____ First	_____ MI
_____ Address		
_____ City	_____ State	_____ Zip
(_____)_____ Telephone	_____ Email	

Send Transcripts To

_____ Name or Institution	_____ Name or Institution
_____ Address	_____ Address
_____ City State Zip	_____ City State Zip

Student Signature _____ Date _____

Billing Information

_____ Number of Transcripts x \$10.00 = _____	_____ Date Completed _____
Check # _____	<input type="checkbox"/> Cash <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Discover
_____ Name on card	_____ Credit Card Number
_____ Expiration date (MM/YYYY)	