



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. Please allow 3 business days for processing. Call 614-825-6255 for special handling (additional fees may apply).

Please submit the completed form along with payment via email, fax, or mail:

Email: jbrooks@aiam.edu

Fax: 614-825-6279

Mail: Office of the Registrar
6685 Doubletree Ave.
Columbus, Ohio 43229

Please note that payment can also be made by calling reception and giving information over the phone.

Check box if this is to be sent with a NCCAOM Pre-Graduation Verification Form.

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)	CSV Number