



Office of Enrollment Management
41 Bee Street
MSC 203
Charleston SC 29425-2030

Transcript Request Form

College: Dental Medicine Graduate Studies Health Professions
 Medicine Nursing

Program: _____

Name _____ SSN _____
Last First Middle or Birth

Current address _____
Street City State Zip

School _____

Date of enrollment _____

I authorize the release of a transcript of my academic record to the Medical University of South Carolina.

Signature _____ Date _____

Registrar: This person is applying for admission to the Medical University of South Carolina. Please enclose this form along with an official transcript addressed to MUSC - Office of Enrollment Management.

Be sure to include instructions on how to interpret the transcript and an explanation of your grading system. If the transcript is not in English, include an English translation. If a copy of the student's academic record cannot be forwarded, please indicate the reasons.



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