Falcon Institute of Health and Science
3045 Avenue B, Bethlehem PA 18017
www.falconihs.com
Phone: 610-253- 2527 Fax: 610-438-0201 email: info@falconihs.com

OFFICAL TRANSCRIPT REQUEST FORM

Please read the following carefully before proceeding.

Your account must be cleared of all holds before your request can be processed.

Failure to complete any one of the fields below may delay or prevent your request from being processed:

- Current Full Name and Former Name (if applicable)
- Approximate Date of Attendance
- Signature
- Date of Birth
- Last 4 digits of Social Security
- Daytime Phone Number
- Address to which your transcript(s) are mailed

Submission Instructions:

- ☐ In person at Falcon Institute of Health and Science
- ☐ By Mail to Admissions Office, 3045 Avenue B Bethlehem, PA 18017
- ☐ By Fax to 610-438-0201

Service Option and Fees:

- ☐ Regular Service ($25 fee per Transcript) Processed within five business days of receipt of the Official Transcript Request Form and the payment, and then mailed by first class USPS mail.
- ☐ In Office Pick- Up ($20 fee per Transcript) Processed with three business days of receipt of the Official Transcript Request Form and the payment.

Payment Method:

- ☐ Check or Money Order payable to : Falcon Institute of Health and Science
- ☐ Credit Card

Student Information:

Current Full Name (required)	Former Name (if applicable)
Date of Birth (required)	XXX-XX- Last 4 digits of Social Security (required)
Day Time Phone (required)	Email Address
Approximate Dates of Attendance (required)	

All outstanding school financial obligations are met? ___ Yes ___ No

Transcript requests will not be granted for individuals who have an outstanding debt to Falcon Institute of Health and Science.

Recipient Name and Address for Transcript Delivery (required):

Note: You must use separate forms if you wish to send transcripts to more than one location.

Signature and Date:

Signature (required for release of records)	Date

OFFICE USE ONLY:

Received by	Date received
Payment Received	Date Request Processed

CREDIT CARD PAYMENT FORM FOR OFFICAL TRANSCRIPT REQUEST:

_____ _____

Student's Name (required) Cardholder's Name

_____ _____

Cardholder's Phone (required) Cardholder's Email Address

I authorize the Falcon Institute of Health and Science to charge (amount in U.S. Dollars) $_____ to the following credit card account:

Type of Card (check one): MasterCard ☐ VISA ☐ Discover ☐

Credit Card Number: _____

Expiration Date (MM/YYYY): _____

CVV: _____ (American Express on front, others on back)

Credit Card Billing Address:

_____

Address

_____

Address

_____ _____ _____

City State Zip

_____ _____

Signature (required) Date