**Falcon Institute of Health and Science**

***3045 Avenue B, Bethlehem PA 18017***

[***www.falconihs.com***](http://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:

Please complete the Official Transcript Request Form and submit it to [**Registrar@FalconIHS.edu**](mailto:Registrar@FalconIHS.edu)

All requests for transcripts, as well as any questions or follow-ups related to transcripts, should also be directed to [**Registrar@FalconIHS.edu**](mailto:Registrar@FalconIHS.edu)

Transcript Request Fees:

Transcript Request Fee: $35 per transcript request.

Processing Time: Transcripts will be processed within five business days of receipt of the Official Transcript Request Form.

Delivery Method: Transcripts will be mailed via USPS mail.

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)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_XXX-XX-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth (required) Last 4 digits of Social Security (required)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Day Time Phone (required) Email Address**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Approximate Dates of Attendance (required)**

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.

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Tuition and Fee Balance:

* Official Transcripts will not be released if there is any outstanding balance of tuition and fees. Official Transcripts will only be released once the balance is paid in full, and the requester has a zero balance. This policy applies to all requesters, regardless of the date of attendance.
* If student has a balance on their student ledger, the processing time will vary based on when the balance is paid in full. Once the balance is cleared, the transcript request will be processed within five business days from the date of full payment.

Signature and Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature (required for release of records) Date**

CREDIT CARD PAYMENT FORM FOR OFFICAL TRANSCRIPT REQUEST:

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**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**

**FOR OFFICE USE ONLY:**

Transcript Release Request Approved □ Date: \_\_\_\_\_\_\_\_\_\_\_

Transcript Release Request Denied □ Date: \_\_\_\_\_\_\_\_\_\_\_

**Revised 3/20/24**