



# WORLD MEDICINE INSTITUTE

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## TRANSCRIPT REQUEST FORM

Student Name: \_\_\_\_\_ Date of Request: \_\_\_\_\_

Present Address: \_\_\_\_\_  
Street Address or PO Number

\_\_\_\_\_  
City, State

\_\_\_\_\_  
Zipcode

\_\_\_\_\_  
Home Phone

\_\_\_\_\_  
Work/Cell Phone

Check one:

Graduate \_\_\_\_\_

Non-graduate \_\_\_\_\_

Current student \_\_\_\_\_

Mail transcript(s) to:

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

Transcripts will not be issued unless all obligations are cleared. Official academic transcripts on your record from other institutions must be obtained from the institution issuing the credit. A \$15.00 non-refundable fee is required for each transcript requested.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

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### FOR OFFICE USE

No. of copies: \_\_\_\_\_

Amount paid: \_\_\_\_\_

Date transcripts sent: \_\_\_\_\_

Registrar initial: \_\_\_\_\_