



American University of the Caribbean  
*School of Medicine*

# Transcript Request

## Requestor Information

**Please enter all fields in order for your request to be processed.**

If you are applying for licensure in California, Massachusetts or Illinois the transcript fee is included in the \$125 processing fee. For all other states please use this request form.

Student #: \_\_\_\_\_ AAMC Number: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code Country

Phone #: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Matriculation Date: \_\_\_\_\_ Anticipated/Graduation Date: \_\_\_\_\_

**What is this transcript for? (Please circle one)**

Licensure

ECFMG/Match

Fellowship

Transfer

Employment

**Are you currently licensed in any state(s)?**  Yes  No

If yes, provide State and Lic #: \_\_\_\_\_

## Recipient(s)

Indicate where you want us to send the transcript(s).

### First Recipient:

Name/Title of Recipient: \_\_\_\_\_

Name of Business or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code Country

### Second Recipient:

Name/Title of Recipient: \_\_\_\_\_

Name of Business or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code Country

### Third Recipient:

Name/Title of Recipient: \_\_\_\_\_

Name of Business or Hospital: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip Code Country

# Payment Options

## If paying by check...

Please make the check made payable to "AUC." Send check and completed form to:

Attention: Mollie King

Medical Education Administrative Services

901 Ponce de Leon Blvd., Suite 700

Coral Gables, FL 33134

## If paying by credit card...

1. Complete and sign the Credit Card Authorization form (below) and be sure to provide your CVC code (at the bottom of the form).

2. Fax your form to Mollie King at 305-444-6791.

-or-

3. Scan and e-mail your form to mking@meas.aucmed.edu.

# Transcript Request

## Fees

Refer to fee-schedule below for cost of each request. Please allow 3 to 4 weeks for processing.

| Category                 | Fee  | Quantity | Amount   |
|--------------------------|------|----------|----------|
| Students                 | \$10 | _____    | \$ _____ |
| Graduates                | \$15 | _____    | \$ _____ |
| Withdrawn                | \$30 | _____    | \$ _____ |
| <b>Total Amount Due:</b> |      |          | \$ _____ |

\*All fees are non-refundable.

## Credit Card Information

Credit Card Type (Visa and Master Card Only): \_\_\_\_\_ Credit Card #: \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Please enter three-digit CVC Code at bottom.  
Once authorization is received, it will be cut out and shredded.

Name of Student/Applicant Student/Applicant Mailing Address: \_\_\_\_\_

Name on Card (Print) Credit Card Billing Address: \_\_\_\_\_

Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

---

## For Office Use Only:

Date Received: \_\_\_\_\_ Received by: \_\_\_\_\_

Authorization Number: \_\_\_\_\_

Three-digit CVC Code: \_\_\_\_\_