



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 #: _____

State and Lic # (additional): _____

Please check type of license:

- [] Resident [] Direct Patient Care [] Administration [] Medical Teaching [] Medical Research
[] Retired [] Non-Patient Care [] Semi-Retired [] Not Active [] Temporarily Not in Practice

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Withdrawn	\$30	_____	\$ _____
Total Amount Due:			\$ _____

*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: _____