Sovah - School of Health Profession's Nursing Program
(Formerly: Danville Regional Medical Center)
Transcript Request
142 S Main Street, Danville, VA 24541
Phone: (434)-799-4443 Fax: (434)799-4563
Please allow 7-10 days for processing.

Student Name: _____

Last name at time of graduation (**if different from above**):_____

Last Date Attended: _____ Class of: _____ DOB:_____

Phone #: _____

Address: _____
Street City State Zip

Total # copies requested: _____ # Official Copies: _____ # Unofficial copies _____

Fee: $10.00 per transcript **Total amount to complete request $**_____

Note: This fee is for NURSING GRADUATE TRANSCRIPTS ONLY.
For Radiologic Technology transcript requests please visit the Radiologic Technology page for complete directions!

☐ **Pick up**

☐ **Fax** _____
Name of business or contact person **Fax #**

☐ **Mail to** _____
Name of business or contact person **Phone #**

Address: _____
Street **City** **State** **Zip**

Please make checks payable to: Sovah - School of Health Professions

Charge Card Request by Phone:

I approve Sovah- School of Health Professions to charge my account in the amount of $ _____.

☐ Master Card ☐ Visa
☐ Discover ☐ American Express

_____ _____ _____
Card # Expiration Date V-Code (3 digit #)

Note: Failure by the student to pay proper financial obligations may result in the withholding of official transcripts. In accordance with the Family Educational Rights and Privacy Act of 1974. The attached record is being released with the consent of the student. This authorization does not permit you to transmit this information to other individuals, agencies or organizations other than yourself and in order to do so, you must secure the written consent of the student.

_____ _____
Signature Date

For School Use:

☐ Picked up ☐ Faxed ☐ Mailed Date ____/____/_____ Total Fee Paid $_____

Request Completed By: _____

7/93; Revised 12/2017