CATHOLIC DISTRICT SCHOOL BOARD OF EASTERN ONTARIO

REQUEST FOR TRANSCRIPT

Authorization and Consent

TRANSCRIPT FEE: $5.00

NOTE: Your transcript request will not be processed until receipt of this completed form with the applicable non-refundable fees and a copy of photo ID showing your date of birth. Please allow one week for processing.

APPLICANT INFORMATION (Please Print)

Last Name: Last/Family Name: *(while in school)*	First Name: Other Names Used:	Middle Name:	Gender: ☐ M ☐ F	Date of Birth: *(year/month/day)*

Last Secondary School Attended:	Last Year of Attendance:	CDSBEO Student Number: *(if known)*	OEN –Ontario Education Number: *(if known)*

Current Mailing Address:	City/Country:	Postal Code:	Home: ( ) Bus: ( ) Fax: ( ) E-Mail:

Reason for Request:

☐ University ☐ College ☐ Re-entry ☐ Employment ☐ Other (Please specify):

DISTRIBUTION INFORMATION (Please Print)

No. of Transcripts Required:	I, the undersigned do hereby authorize the CDSBEO to release a copy of my student transcript(s) as indicated below: Signature:	Date:

PICKUP

☐ By Applicant

☐ By Other: _____

Indicate Full Name of Authorized Person

Additional Comments:_____

_____

Applicant will be notified when transcript is available for pick up. Two pieces of identification must be presented to obtain OST.

Date OST Received: _____

Signature: _____

MAIL

☐ To Applicant (at address indicated above)

☐ To Other: *(if mailing to more than one location, provide details reverse)*

_____

Name

_____

Mailing Address

_____

City *Prov.* *Postal Code*

Fax #:

Post-Secondary Ref. No (if applicable) _____

FOR OFFICE USE ONLY *(To be completed by Office Personnel)*

Payment received: Amount: $_____ ☐ Cash ☐ Money Order	☐ Proof of identity received/confirmed _____ *Signature of Office Personnel*
Completed by:	Date prepared: