GRAHAM HOSPITAL SCHOOL OF NURSING
RELEASE OF STUDENT INFORMATION AUTHORIZATION

Date: _____/_____/_____

I request the Graham Hospital School of Nursing to send:

_____an official transcript

_____an unofficial transcript

_____other (specify)_____

TO: _____
Name

_____
Street

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City *State* *Zip Code*

Maiden Name:_____ Class of _____

S.S. # _____/_____/_____

_____
Student Signature

_____
Street

_____
City *State* *Zip Code*

_____
Phone *Email*

NOTE: Please remit $5.00 for each document requested.

<u>Mail request form to:</u>
Graham Hospital School of Nursing
Pam Ritter, Coordinator of Admissions, Recruitment & Financial Aid
210 W. Walnut
Canton, IL 61520

2018