School of Radiologic Technology

Administrative and Classroom Location:
4 West Main Street, Lower Level
Riverhead, New York 11901
Office #: (631) 548 – 6183

TRANSCRIPT REQUEST FORM

- It is the policy of Peconic Bay School of Radiologic Technology to adhere to the Federal "Right to Privacy Act" in keeping all students' records in the strictest confidence.
- Each student's academic and clinical records shall be kept on file at Peconic Bay School of Radiologic Technology and shall not be released to other institutions without the written consent of the student in question.
- A form should be completed for each transcript requested.
- A copy of the state driver's license should be attached.

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(Last Name) (First Name) (MI)

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(Name While Attending Peconic Bay School of Radiologic Technology)

Year of Graduation: _________ Last Four of your SSN: __________ Date of Birth: _________________

Print Name:

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Graduate's Current Address: ____

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Graduate's Signature: ____

Date of Signature: ____

Method of Payment & Processing:

a) Check made payable to "Peconic Bay Medical Center" for $10.00: ______________

b) Credit Card Information: Master Card or Visa `or American Express or Discover #

____ Exp. Date: ___________ Security Code: ___________

c) Cash $10.00 __________________

School Secretary Signature: _________________________________ Processed on: _________________