Capital Area School of Practical Nursing
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RELEASE OF TRANSCRIPT

_____
Name (Please Print)

_____
Name under which I graduated

_____
SS#

_____
Address (Please Print)

_____
City State Zip Code

_____
Phone Number

I graduated from CASPN on _____

I attended CASPN from _____ to _____but did not graduate.

I HEREBY AUTHORIZE THE CAPITAL AREA SCHOOL OF PRACTICAL NURSING TO RELEASE MY PERMANENT SCHOOL RECORDS, INCLUDING GRADES, IMMUNIZATION RECORDS AND EVALUATIONS TO THE FOLLOWING:

_____
Institution/Individual to which I wish my transcript released.

_____
Address of the above City State Zip

Cash/Money Order enclosed
$5.00 for each transcript _____Yes

No Checks will be accepted

_____
SIGNATURE

_____
DATE