



Florida School of Massage

6421 SW 13th Street | Gainesville, Florida 32608

phone: 352.378.7891 | fax: 352.381.8808 | toll free: 877.589.2713

www.floridaschoolofmassage.com | info@floridaschoolofmassage.com

TRANSCRIPT AND DIPLOMA REQUEST FORM

(COMPLETE AND MAIL OR FAX TO 352-381-8808)

I REQUEST MY SCHOOL RECORDS TO THE PARTIES INDICATED BELOW FOR THE PURPOSES STATED. I UNDERSTAND THAT YOU CANNOT PROCESS THIS REQUEST WITHOUT MY SIGNATURE AND THIS COMPLETED FORM WITH THE APPROPRIATE FEES PAID.

SIGNATURE: _____
(PLEASE INCLUDE YOUR NAME AS IT WAS WHEN YOU ATTENDED SCHOOL)

PRINTED NAME: _____ PROGRAM DATE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____

E-MAIL ADDRESS: _____

WOULD YOU LIKE TO SIGN UP FOR OUR MONTHLY CONNECTIVE ISSUE ONLINE? YES NO

ARE YOU A LICENSED THERAPIST? YES NO IF YES, IN WHICH STATE ARE YOU LICENSED _____ LIC # _____

FOR WHAT PURPOSE ARE YOU MAKING THIS REQUEST? PERSONAL JOB EDUCATION REPLACEMENT OF ORIGINAL
STATE LICENSURE NATIONAL CERTIFICATION EXAM OTHER: _____

TRANSCRIPT PROVIDED IS ORIGINAL TRANSCRIPT FROM STUDENT'S FILE. FOR ADDITIONAL RESEARCH, JUSTIFICATION LETTERS, AMENDED TRANSCRIPTS, OR FURTHER ACTION BY ADMINISTRATIVE STAFF A MINIMUM \$25 FEE WILL BE REQUIRED. MINIMUM FEE FOR NEW YORK STATE LICNSURE IS \$75. PLEASE CALL THE SCHOOL FOR A CONSULTATION.

DOCUMENT	QUANTITY NEEDED	TOTAL
OFFICIAL TRANSCRIPT (SENT DIRECTLY TO INSTITUTION)	_____ x \$15	= _____
TRANSCRIPT (RELEASED TO STUDENT)	_____ x \$15	= _____
DIPLOMA (WALL CERTIFICATE)	_____ x \$15	= _____
NOTARIZED DIPLOMA	_____ x \$15	= _____
OTHER (CALL THE SCHOOL FOR CONSULTATION & PRICE)	_____ x \$	= _____
TOTAL:		_____

WHERE DO YOU WANT THE DOCUMENT(S) SENT? (USE BACK OF PAGE IF MORE THAN ONE.)

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE NUMBER: _____

CREDIT CARD INFORMATION (IF NOT PAYING BY CASH OR CHECK MADE PAYABLE TO "FSM")

TOTAL AMOUNT: _____ TYPE OF CREDIT CARD: MASTER CARD VISA DISCOVER 3-DIGIT SECURITY CODE _____

CREDIT CARD NUMBER: _____ EXPIRATION DATE: _____

NAME ON CREDIT CARD: _____

BILLING ADDRESS (IF IDFFERENT FROMABOVE): _____

FOR OFFICE USE ONLY

DATE: _____

DATE TRANSCRIPT/DIPLOMA(S) MAILED: _____ PAYMENT RECEIPT #: _____

ADMINISTRATOR WHO HANDLED THIS REQUEST: _____

PLEASE FILE THIS IN STUDENT'S FOLDER WHEN ACTION IS COMPLETED.