

UNIVERSITY OF ILLINOIS
COLLEGE OF MEDICINE
AT ROCKFORD

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Request for Transcript, Certified Diploma copy, MSPE or Dean's Letter

Complete all sections of this form

Date of Request: _____ SSN / UIN: _____
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Make check payable to the University of Illinois.

Number of transcripts requested	_____ @ \$5.00 per transcript = Total amount due	\$ _____
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STUDENT / ALUMNI SIGNATURE (Must have original signature – Electronic Signature not accepted)

X _____

Form may be faxed to 815-395-5979, emailed as attachment to allenam@uic.edu or mailed to address as listed at top.

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