CMCC
Canadian Memorial Chiropractic College

Request for Transcript

Last Name:_____ First Name:_____

Date of Birth (dd/mm/yy): _____ Year of Graduation from CMCC:_____

Phone #: _____ Email:_____

Current Address: _____

_____

_____

Institution to which you wish your transcript sent:

Name & Title of recipient (e.g. Registrar): _____

Institution: _____

Address: _____

_____

_____

Phone #: _____ Fax #: _____

Fee for an Official Transcript is $15.00 Canadian (Transcripts Released upon Receipt of Fee)

Cheque enclosed _____ AMEX_____ Visa _____ MasterCard _____

Credit Card Number: _____ Expiry Date: _____

I authorize the Canadian Memorial Chiropractic College to send an official transcript of my academic record at CMCC to the institution at the address noted on this form:

Signature: _____ Date: _____

PLEASE FAX YOUR COMPLETED FORM TO 416-646-1114, or EMAIL TO: admissions@cmcc.ca