



New York
COLLEGE
OF HEALTH PROFESSIONS

New York College of Health Professions
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Transcript Request Form

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*****PLEASE ALLOW 7 TO 14 DAYS FOR DELIVERY (14 TO 21 DAYS IF YOU GRADUATED/WITHDREW PRIOR TO 1999)*****

NAME ON RECORD: _____ STUDENT ID NUMBER: _____

PRESENT NAME (IF DIFFERENT): _____

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PROGRAM: Acupuncture Massage Therapy Oriental Medicine Other

DATES OF ATTENDANCE: _____ TO _____

GRADUATION DATE: _____ DEGREE: _____

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