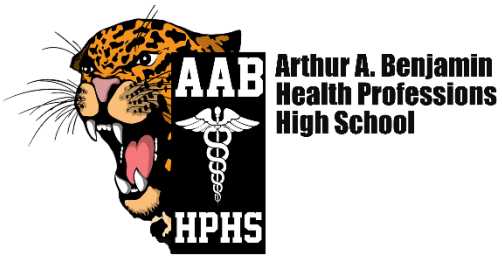


Arthur A. Benjamin
Health Professions
High School

# TRANSCRIPT REQUEST FORM

**DATE: _____**

**NAME AT TIME OF GRADUATION: _____**

**DATE OF BIRTH: _____ DATE OF GRADUATION: _____**

**Would you like your transcripts mailed or to pick up in the front office?**

☐ **Mailed** ☐ **Pick up**

**How many copies of your transcripts do you need? _____**

**MAILING ADDRESS:**

**STREET: _____**

**CITY: _____ STATE: _____**

**PLEASE EMAIL A COPY OF A CURRENT PHOTO ID AND THIS FORM TO**

**taryn-marsh@scusd.edu**