



Florida School of Massage

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TRANSCRIPT AND DIPLOMA REQUEST FORM

(COMPLETE AND MAIL OR FAX TO FSM)

I AUTHORIZE FSM TO RELEASE 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 ONLINE NEWSLETTER? YES NO

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

ARE YOU CURRENTLY WORKING AS AN LMT? YES NO IF YES, ARE YOU EMPLOYED _____ OR SELF-EMPLOYED _____

FOR WHAT PURPOSE ARE YOU MAKING THIS REQUEST? PERSONAL JOB EDUCATION REPLACEMENT OF ORIGINAL
STATE LICENSURE NATIONAL CERTIFICATION 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 LICENSURE IS \$150.
PLEASE CALL THE SCHOOL FOR A CONSULTATION.

DOCUMENT	QUANTITY NEEDED	TOTAL
OFFICIAL TRANSCRIPT (SENT DIRECTLY TO INSTITUTION)	_____ x \$20	= _____
TRANSCRIPT (RELEASED TO STUDENT)	_____ x \$20	= _____
DIPLOMA (COPY)	_____ x \$20	= _____
DIPLOMA (WALL CERTIFICATE)	_____ x \$20	= _____
OTHER (CALL THE SCHOOL FOR CONSULTATION & PRICE)	_____ x \$	= _____
RUSH PROCESSING/ADDITIONAL FEE (OTHERWISE, ALLOW 7-10 BUSINESS DAYS)	_____ x \$15	= _____
	TOTAL:	_____

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

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

TELEPHONE/FAX 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 AMEX

CREDIT CARD NUMBER: _____ EXPIRATION DATE: _____

NAME ON CREDIT CARD: _____ 3-DIGIT SECURITY CODE: _____

BILLING ADDRESS (IF DIFFERENT FROM ABOVE): _____

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.