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 LICNSURE 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:	$ 0.00

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.