

THE SOMA INSTITUTE

THE NATIONAL SCHOOL OF CLINICAL MASSAGE THERAPY

Transcript Release Form

Fill out all required information, sign and date the form.
Failure to complete in full will delay processing. Mail to The Soma Institute, Student Records Office
14 E. Jackson Blvd., Suite 1300, Chicago, IL 60604-2232

I, _____ SS# _____ - _____ - _____
(Print Name)

Address _____

City, State, Zip _____

request that a copy of my transcript for the Clinical Massage Therapy Diploma Program be sent to the following address:

I understand that if I am a graduate or withdrawn student that a transcript will not be issued if there are any tuition or other fees outstanding on my account.

Signature _____

Date _____

Please allow up to 14 days for processing your request.

For Office Use Only		
Transcript Release Form Received	_____	_____
	(Date)	(Initials)
Transcript Release Form Sent to Careers Office	_____	_____
	(Date)	(Initials)
Transcript Sent to Careers Office	_____	_____
	(Date)	(Initials)
Transcript Mailed	_____	_____
	(Date)	(Initials)