

BELHAVEN UNIVERSITY

O u r S t a n d a r d i s C h r i s t

TRANSCRIPT REQUEST

PLEASE PRINT

To: _____
College

Date: _____

phone # _____

Address _____

fax # _____

From: _____
Student's Name (Please Print)

Date last attended: _____

Student's Signature

SSN# _____

Address

Date of Birth: _____

City

State

Zip

Telephone Number

Name(s) under which you attended:

Please mail or e-script to:

Please Print

Belhaven College
Graduate & Online Admission
1500 Peachtree Street
Box 279
Jackson, MS 39202

fax: 601-968-5953

IMPORTANT: Prior to sending request to Belhaven, please determine if your school accepts credit card payment and faxed transcript requests.

Credit Card Payment _____

Faxed Requests _____