DALLAS NURSING INSTITUTE
12170 North Abrams Rd. • Suite 200 • Dallas, TX 75243 • Phone: 469-941-8307 • Fax: 214-575-9090

Transcript Request Form

Name_____ _____ _____
Last Name (While enrolled) First Name Middle Initial

Social Security Number _____ Date of Birth _____

Current Address_____

City_____ State_____ Zip Code_____

Phone number_____

Program_____ Graduation Date_____

If transcript is to be sent to a third party, please provide the following information. Otherwise, your transcript will be sent to the current address above:

Name_____

Attn_____

Mailing Address_____

City_____ State_____ Zip Code_____

Please allow 7 to 10 business days for delivery of transcript or information upon receipt of this request. Limited 1 transcript per request. All transcripts are official, sealed and mailed only. I give Dallas Nursing Institute permission to release my transcript as directed above:

Signature_____

Print Name_____

Date_____

This transcript request form may be mailed or faxed to:

Dallas Nursing Institute
12170 North Abrams, Suite 200
Dallas TX, 75243
Fax: 214-575-9090 or registrar@dni.edu