



UNIVERSITY OF COLORADO DENVER

ANSCHUTZ MEDICAL CAMPUS

OFFICE OF THE REGISTRAR
UNIVERSITY OF COLORADO DENVER
CAMPUS Box A054
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Phone 303-724-8059
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Anschutz Medical Campus Transcript Request Form

Please complete form, sign, and fax, mail, or e-mail scanned copy. Transcript requests will NOT be processed without a signature or in the event the student has an active financial stop. Only University of Colorado transcripts will be issued. Allow a minimum of three days for processing.

Last Name: _____
First Name: _____
Middle Name: _____
Please provide any previous names: _____
Student ID Number or SSN: _____
Birth Date: _____
Phone: _____
Email: _____
Dates Attended CU: _____ to _____

Send ___ transcripts to:

Send ___ transcripts to:

Last CU Campus Attended: _____
To be mailed now Yes No
Mail after grades have been posted for _____
Mail after degree is posted Yes No
Graduation Date _____
Hold and mail after grade change is posted
Course name and number: _____

Signature: _____

Send ___ transcripts to:

Send ___ transcripts to:

