

Date Mailed/Faxed: _____

TRANSCRIPT REQUEST- FOR ALUMNI USE ONLY

PLEASE ALLOW TWO (2) WEEKS FOR PROCESSING

Date: _____

Your name when you attended Mt. Ararat: _____
Please Print

DOB: ____ / ____ / ____ What year did you Graduate?: _____

Current Phone Number: (____) _____ If you did not graduate - last year attended: _____

I am requesting the following records:

Transcript	_____
Health Record	_____
SAT/AP	_____
Accuplacer	_____
Recommendations	_____
Other (specify)	_____

Send records to: _____

Requested by: _____
Signature

If you are not student – relationship: _____

Mail to: Mt. Ararat High School
Attn: Guidance Dept.
73 Eagles Way
Topsham, ME 04086

OR:

Fax: 207-729-2953