

**\$2.00 fee per transcript**

**Diman Regional School of Practical Nursing  
251 Stonehaven Road  
Fall River, Massachusetts 02723  
508-672-2970**

**INFORMATION NEEDED WHEN TRANSCRIPT IS REQUESTED**

Name: \_\_\_\_\_ Last 4 digits of Social Security # \_\_\_\_\_

If married, give maiden name or the name used while attending school: \_\_\_\_\_

Telephone #: \_\_\_\_\_

**PROGRAM COMPLETED:** LPN\_\_\_\_ CNA\_\_\_\_ Medical Asst.\_\_\_\_ Other:\_\_\_\_\_

**YEAR OF GRADUATION:** MONTH \_\_\_\_\_ YEAR \_\_\_\_\_ Day or Evening \_\_\_\_\_

**OR DATE OF LEAVING PROGRAM:** \_\_\_\_\_

Send transcript to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Release of Information**

To assist the above-named individual in education and occupation placement, school authorities are requesting authorization for release of information in accordance with Chapter 71 of General Laws of the Commonwealth of Massachusetts.

I hereby authorize the release of information as requested to which the above-named individual has applied.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**\*RETURN COMPLETED FORM TO THE ABOVE ADDRESS**