

**Diman Regional Technical Institute**  
**School of Practical Nursing**  
**1082 Davol Street, 2<sup>nd</sup> Floor**  
**Fall River, Massachusetts 02720**  
**Tel: 508-672-2970**  
**Fax: 508-672-2973**

Complete the information requested, and submit the \$5.00 fee made payable to Diman Regional for processing. All requests will be processed within 10 working days.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Name Listed on Diman Records: \_\_\_\_\_

Current Mailing Address: \_\_\_\_\_  
\_\_\_\_\_

Current Telephone # \_\_\_\_\_

Current email address: \_\_\_\_\_

Program Completed/Attended: LPN \_\_\_\_\_ CNA \_\_\_\_\_ Medical Assist \_\_\_\_\_ Other \_\_\_\_\_ Specify \_\_\_\_\_

Year of Graduation (REQUIRED): \_\_\_\_\_ Month: \_\_\_\_\_

**Send Transcript To:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Email Address:** \_\_\_\_\_

**Release of Information**

To assist the above mentioned individual in education and occupation placement, school authorities are requesting authorization for the 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**

**Please do NOT write below this line**

Fee: \$5.00

Paid: \_\_\_\_\_

Mail or Pickup: \_\_\_\_\_