



TRANSCRIPT REQUEST FORM

TMDSAS ID: _____

Entry Year: _____

STUDENT INFORMATION:

Last Name: _____

First and Middle Name: _____

Other Last Names (if different from above): _____

Student ID: _____

Dates of Attendance: _____

Degrees Earned: _____

Dear Registrar:

I hereby request you forward my official transcript(s) to TMDSAS at the following address. Please attach this form or include my TMDSAS ID with my official transcript(s).

Mailing Address:

Texas Medical and Dental Schools Application Service
Attn: Transcripts
P.O. Box 2175
Austin, TX 78768

OR Street Address (for package delivery):

Texas Medical and Dental Schools Application Service
210 W. 7th Street
Austin, TX 78701

Signature

Date

Please enclose this form with the applicant's official transcript(s).

A transcript will be rejected by TMDSAS under any of the following conditions:

- The transcript was printed more than a year ago
- The Registrar's seal and/or signature is missing
- The transcript is not in a sealed envelope from the Registrar
- The transcript is for the wrong student, or the name of the transcript differs from that on the transcript request form
- The transcript is illegible