



Ohio Institute of Allied Health

School of Integrative Healthcare

To Registrar of: Ohio Institute of Allied Health
6245 Old Troy Pike
Huber Heights, OH 45424
Phone: 937-237-1010 / Fax: 937-237-0506

Please forward an official copy of my academic record to:

Recipient Name: _____

Recipient Address: _____

City: _____ STATE: _____ ZIP: _____

Recipient Phone Number: _____

Students Name
(current): _____

Address: _____

City: _____ STATE: _____ ZIP: _____

Phone Number: _____

Students Name
(while attending): _____

Social Security
Number: _____

Graduation Date: _____

I hereby authorize the Ohio Institute of Allied Health to release my transcript to the organization listed above.

SIGNATURE: _____ DATE: _____