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:_____

Credit Card Payment Authorization: I authorize the $5.00 transcript fee to be charged to Card #_____ **Exp Date**_____ **SC**_____

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

SIGNATURE:_____ **DATE:**_____