Summer School

ARTS AND SCIENCES AT WASHINGTON UNIVERSITY

TRANSCRIPT or DOCUMENT RELEASE

ID Number (if known) ___________________

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Local Address __CB 6504, 6985 Snow Way, St. Louis, MO 63130-4400____ Phone _________________

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My signature below indicates that I am requesting copies of my transcripts or Degree Verification from:

__Official Transcript from University College - Summer School - Washington University in St. Louis
School(s)

Or copies of (other documents listed above)

To be released to:
Christina Zebrowski – Coordinator for Summer School & Programs
CB 1064 January Hall, Room 100

I hereby consent to the University's disclosure of this information from my education records to the Person or institution noted above.

This release will be in effect: (ck one) __X__ One time only. ______ Until withdrawn in writing

Signed, ____ Date _______________________

Dates of Attendance at Washington University: ______07/17/2017______ to ___08/17/2017____

University College Authorization: Christina Zebrowski________________
Signature

__Christina Zebrowski______________________
Print Name

Date __08/15/2017________

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