Transcript Request Form

Student Full Name (and former name if applicable)

________________________________________________________________________

Date of Birth  __________________________________________________________________________

Dates of attendance at GAB  __________________________________________________________________________

Phone number  __________________________________________________________________________

Address where transcript should be mailed: (Note that official transcripts must be mailed directly to educational institution. Unofficial transcripts can be mailed to student directly)

1.  

2.  

3.  

4.  

Submit completed form to:

Tyrene Neil
Student Services Coordinator
2895 Vineville Ave.
Macon, GA 31204

tneil@doe.k12.ga.us
FAX 478-752-1745

I authorize Georgia Academy for the Blind to release records to entities listed above.

Signature:__________________________________________

Office Use Only
Date Request received___________________________
Date transcript mailed___________________________
Signature________________________________________

Georgia Department of Education
"Educating Georgia’s Future"
Richard Woods, State School Superintendent