School of Radiologic Technology
Jacksonville, Florida

Date:

Your Name:

Your Address:

City, State, Zip Code:

Your Phone #:

Your Email:

Shaun B. Harrell, M.Ed., RT (R) ARRT

Program Director, School of Radiologic Technology Radiology

Education, Bin # C-90

655 W. 8th Street, Jacksonville, Florida, 32209

Mr. Harrell,

I am _____an alumnus of your institution. My graduation date from the Radiography program was _____. My dates (month/year) of training were from _____ to _____.

I write this letter to request that my transcript(s) be sent to a college, university, employer, or other. Please mail my transcript(s), at your earliest convenience, to the address listed below. I may also opt to pick up my transcript in person. Without reservation, I fully grant permission to the UF Health – Jacksonville School of Radiologic Technology faculty or designee to access my student records and send them to the entity listed below. Thank you for your time and efforts.

Respectfully,

(Your Signature)

Name of Institution or Employer:

Attention:

Address: