

# THE SOMA INSTITUTE

THE NATIONAL SCHOOL OF CLINICAL MASSAGE THERAPY

## Transcript Release Form

Fill out all required information, sign and date the form.  
Failure to complete in full will delay processing. Mail to The Soma Institute, Student Records Office  
55 East Jackson Blvd., Suite 300, Chicago, IL 60604

I, \_\_\_\_\_  
(Print Name)

Last four digits of SS# \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

request that a copy of my transcript for the Clinical Massage Therapy Diploma Program be sent to the following address:

\_\_\_\_\_  
\_\_\_\_\_

I understand that if I am a graduate or withdrawn student that a transcript will not be issued if there are any tuition or other fees outstanding on my account.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

**Please allow up to 14 days for processing your request.**

### For Office Use Only

Transcript Release Form Received	(Date) _____	(Initials) _____
Transcript Release Form Sent to Careers Office	(Date) _____	(Initials) _____
Transcript Sent to Careers Office	(Date) _____	(Initials) _____
Transcript Mailed	(Date) _____	(Initials) _____