Northwell Health℠

Emergency Medical Institute

TRANSCRIPT REQUEST

National College Credit Recommendation Service (National CCRS)

Please complete as much information below as possible

Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone: ( ) _____ Cell: ( ) _____

E-Mail: _____ @ _____

NYS Provider (EMT) Number: _____

Social Security Number: _____ - _____ - _____

Date of Birth _____ / _____ / _____ Course Number: _____

Level: _____ Year Graduated: _____

Instructor: _____ Course Location: _____

Office Use Only

Course # _____ I/C: _____ GPA: _____ Letter Grade: _____

Course Start Date: _____ Course End Date: _____

I _____ affirm that the information on this document is contained within the official records kept during the regular course of business of the Northwell Health Emergency Medical Institute.

Signed: _____

Title: _____ Date: _____

Northwell Health℠

Emergency Medical Institute

Affirmation: I _____, hereby request that an Official Transcript of my Northwell Health Emergency Medical Institute (EMI) program(s) be transmitted to the following educational institution:

Name of Institution: _____

Address: _____

City: _____ State: _____ Zip:_____

Attention of: _____

IF OTHER THAN A LEARNING INSTITUTION

Affirmation: I _____, hereby request that an Official Transcript of my Northwell Health Emergency Medical Institute (EMI) program(s) be transmitted to the following recipient:

Name of Recipient: _____

Address: _____

City: _____ State: _____ Zip: _____

Attention of: _____

RELEASE OF INFORMATION AUTHORIZATION

I _____ hereby authorize the Course Sponsor Administrator of the Northwell Health Emergency Medical Institute (EMI) to release the above information to the organization(s) listed herein.

Signed: _____ Date: _____