Berwick Area School District
500 Line Street
Berwick PA 18603
(570) 759-6400

Please fax form to 570-759-7019 or mail to the address above, Attn: Child Accounting.

INFORMATION NEEDED TO REQUEST TRANSCRIPTS

NAME: _____

MAIDEN NAME: _____

DATE OF BIRTH: _____

DATE OF GRADUATION OR WITHDRAWAL: _____

PLEASE CHECK INFORMATION YOU ARE REQUESTING:

( ) TRANSCRIPTS ONLY

( ) ALL RECORDS

( ) HEALTH RECORDS

PLEASE LIST CONTACT INFORMATION FOR WHEN RECORDS ARE READY FOR PICKUP:

_____

IF REQUESTING MAILING OF TRANSCRIPTS, PLEASE GIVE COMPLETE ADDRESS TO SEND THE TRANSCRIPTS:

_____

_____

THE RECORDS WILL BE PROCESSED WITHIN 7 TO 10 BUSINESS DAYS OF YOUR REQUEST.

DATE: _____