Please mail form to: **Berwick Area School District**
Attn: Child Accounting Office
500 Line Street
Berwick, PA 18603

Or E-Mail: **kmoyer@berwicksd.org**

INFORMATION NEEDED TO REQUEST TRANSCRIPTS

NAME: _____
MAIDEN NAME: _____
DOB: _____ SS#_____

DATE OF GRADUATION OR WITHDRAWAL: _____

CHECK INFORMATION NEEDED:

- **( ) TRANSCRIPTS ONLY**
- **( ) ALL RECORDS**
- **( ) HEALTH RECORDS**

Contact number when records are processed and ready for pick-up. _____

If requesting mailing of transcripts, please give complete address as to where they will be sent:

_____
_____
_____

The records will be processed within 7 to 10 business days of your request.

Thank You. **Date: _____**