Cartersville School System

# TRANSCRIPT REQUEST

Note: Please allow 72 hours for processing on all transcript requests.

Name: _____
(Photocopy of picture I.D. must be included)

Maiden or any other name(s), if applicable: _____

Phone #: _____ Alternate phone #: _____

Date of birth: _____

Graduated: _____ Yes _____ No (If No, in what grade did you leave? _____)

Year graduated: _____ or, Year last attended: _____

_____ I will pick up my transcript/records (Please allow 72 hours)

_____ I need my transcript mailed to: (Name and address required)

_____

_____

_____

Signature: _____ _____
(I certify that I am the person whose record is being requested) Date

Submit requests to: Cartersville City Schools
Attn: Sonya Noble
Mail to: PO Box 3310, Cartersville, GA 30120
In person at: 15 Nelson Street, Cartersville
Fax to: 770-387-7476
Email: snoble@cartersvilleschools.org

**PICTURE I.D. MUST BE INCLUDED**

**For office use only:**
Date processed: _____
Processed by: _____
Picked up: _____
Mailed: _____