



## 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: \_\_\_\_\_ Date \_\_\_\_\_  
(I certify that I am the person whose record is being requested)

Submit requests to: Cartersville City Schools  
Attn: Betsy Holt  
PO Box 3310, Cartersville, GA 30120

In person at: 15 Nelson Street, Cartersville, GA 30120  
Fax to: 770-387-7476  
Email: [bholt@cartersvilleschools.org](mailto:bholt@cartersvilleschools.org)

**For office use only:**

Date processed: \_\_\_\_\_  
Processed by: \_\_\_\_\_  
Picked up: \_\_\_\_\_  
Mailed: \_\_\_\_\_

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