



GED TRANSCRIPT REQUEST FORM

PLEASE PRINT:

NAME _____ **MAIDEN** _____

DOB _____ **ADDRESS** _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE _____ **YEAR LAST TEST WAS TAKEN*** _____

* Please note the College only retains GED Transcript records for 5 years. If it has been longer than 5 years since your last test was taken, please contact the RI Department of Education at 401-222-8948.

I hereby authorize the Community College of Rhode Island, Center for Workforce & Community Education, to release my transcript to the following organization(s):

1. ORGANIZATION _____

ADDRESS _____

COURSE # GEDT-6000-001 **\$5.00**

2. ORGANIZATION _____

ADDRESS _____

COURSE # GEDT-6000-002 **\$5.00**

3. ORGANIZATION _____

ADDRESS _____

COURSE # GEDT-6000-003 **\$5.00**

All requests for GED transcripts are provided upon payment of a \$5.00 fee, for each transcript.

SIGNATURE _____

DATE _____

TOTAL PAID _____