ST.VINCENT AND THE GRENADINES COMMUNITY COLLEGE
TRANSCRIPT REQUEST FORM

Read the information before completing this form.

Date: DD / MM / YY _____

Name: _____ **SVGCC ID#:** _____
(First Name, Middle Initial, Last Name)

Date of Birth: DD / MM / YY _____ **Gender:** Male ☐ Female ☐

Contact #:_____ **E-mail:**_____

Division Attended: DASGS ☐ DTE ☐ DTVE ☐

Programme of Study: _____

If CAPE or GCE, please state the subjects taken: _____

_____

Period of Enrollment at SVGCC: From: _____ **To:** _____

University/College/Application Reference # or ID: _____

University/College / Recipient Address: _____

_____

_____

Recipient E-mail: _____

Recipient Contact #: _____

Fees must be paid before transcripts are processed. Please note that a transcript may take a minimum of 10 working days to be processed.

Please indicate how you wish the transcript to be delivered to the Recipient. **(Transcripts are not emailed to applicants, only from institution to institution)**	
E-mail (only to institutions)	
Registered mail only	
Both registered mail and e-mail	
To be collected	

For Official Use Only

Fee $20.00 per copy	Paid		No. of copies		Receipt Number
*$10.00 per copy	Paid		No. of copies		

Fee is only applicable for transcripts which are going to be sent to another Division of the SVGCC

Prepared by: _____ **Date:** DD / MM /YY _____ **Signature:** _____

Verified by: _____ **Date:** DD / MM / YY _____ **Signature:** _____

Registry, Registrar's Office, SVGCC, P.O. Box 829, Telephone: 457 4503 Ext. 369

Revised March 2025