



**Illinois College of Optometry
Registrar's Office**

ACADEMIC TRANSCRIPT REQUEST

Name _____ Year of Graduation _____

Last Four Digits of Social Security Number _____ Birth Date _____

Address _____

City, State & Zip _____

E-mail Address _____ Telephone Number _____

Please mail and/or email my transcript to the following agency:*

* Note that most agencies with general email inboxes will not be able to open our encrypted transcript emails. If requesting email delivery, the direct email of a specific employee is highly preferred.

Signature (Handwritten or Adobe Digital Only)

Date

Submit completed forms to registrar@ico.edu.

*Please allow up to 2-3 business days for processing.
You will be notified by email when the transcript has been sent.*