

# TRANSFER STUDENT DISCLOSURE FORM REQUEST

**Top Portion to be completed by Student and brought to the attending/previously attended school for completion by the Dean of Students Office or equivalent.**

STUDENT’S AUTHORIZATION TO DISCLOSE INFORMATION IN EDUCATION RECORDS PURSUANT TO FAMILY EDUCATIONAL RIGHTS AND PRIVACY ACT OF 1974, AS AMENDED.

I Student ID#

Give my permission for (name of institution)

to release information regarding my student records to UW Oshkosh College of Nursing. This release is to stay in effect until I am no longer enrolled at UW Oshkosh. Form must be returned to UW Oshkosh College of Nursing.

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 Student Signature Date

# To be completed by College/School/Institution attended by above named student:

As the appropriate representative of (name of institution) I acknowledge that the above name student is/was a student in good-standing (academic and conduct) while attending our facility

□ Yes □ No If No, please explain with attached supporting documentation:

Signature: Date:

Place School Seal here or enclose your school business card.

Please email this completed form to the student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_