

**BULLARD-HAVENS TECHNICAL HIGH SCHOOL**

500 Palisade Avenue

Bridgeport, CT 06610

Phone: 203-579-6333

\*Please email completed form to: [bullard.counseling@cttech.org](mailto:bullard.counseling@cttech.org)

**OFFICIAL TRANSCRIPT REQUEST FORM**

NAME: \_\_\_\_\_  
First Middle Last

Maiden Name/Other name used at graduation: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

D.O.B.: \_\_\_\_\_ YEAR OF GRADUATION: \_\_\_\_\_ TRADE: \_\_\_\_\_

TELEPHONE NUMBER: \_\_\_\_\_ EMAIL ADDRESS: \_\_\_\_\_

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☐ **Mail Transcript:**

NAME/SCHOOL/BUSINESS: \_\_\_\_\_  
\_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

☐ **Fax:**

NAME: \_\_\_\_\_

FAX NUMBER: \_\_\_\_\_ ATTENTION: \_\_\_\_\_

☐ **Pick Up:**

NAME OF PERSON PICKING UP: \_\_\_\_\_

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Please provide the complete name and address of the institution, as well as the specific person or office who will receive your transcript. Please allow up to 3 working days for processing, as transcripts are processed on a first come, first served basis.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

**OFFICE USE ONLY**

Date Mailed: \_\_\_\_\_

Date Faxed: \_\_\_\_\_

Processed by: \_\_\_\_\_