



# RECORDS REVIEW REQUEST FORM

UNIVERSITY of NORTH TEXAS HEALTH SCIENCE CENTER *at Fort Worth*

Office of the Registrar

3500 Camp Bowie Boulevard • Fort Worth, Texas 76107-2699

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**NAME:** \_\_\_\_\_ **SS#:** \_\_\_\_\_

**CLASSIFICATION:**

**D.O. (Class of \_\_\_\_\_)**

**MS**

**PHD**

**P.A. (Class of \_\_\_\_\_)**

**MPH**

**DPH**

**I hereby request that the people listed below be permitted to review my academic records as maintained by UNTHSC and/or the Office of the Registrar.**

- 1.) \_\_\_\_\_  
**Name** \_\_\_\_\_ **Department** \_\_\_\_\_
- 2.) \_\_\_\_\_  
**Name** \_\_\_\_\_ **Department** \_\_\_\_\_
- 3.) \_\_\_\_\_  
**Name** \_\_\_\_\_ **Department** \_\_\_\_\_

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

\_\_\_\_\_  
**Date**