

**OFFICE OF ADMISSION AND RECORDS**  
Institute of Clinical Acupuncture and Oriental Medicine  
100 N. Beretania Street, #203 B  
Honolulu, Hawaii 96817

**REQUEST FOR OFFICIAL TRANSCRIPT**

I, \_\_\_\_\_  
Last Name First Name Middle Name

AKA (if applicable) \_\_\_\_\_

Address: \_\_\_\_\_  
Street Apt. #

\_\_\_\_\_ City State Zip Code

Date of Birth: \_\_\_\_\_ Phone \_\_\_\_\_ Email: \_\_\_\_\_

Check:  ICAOM Students/Graduates  Former Big Island **HICOM** students  
 Student Loans was Discharged/Forgiven.

Date of Attendance: from \_\_\_\_\_ to \_\_\_\_\_  
Month/Year Month/Year

I, the above person request and authorize ICAOM to send a copy of my official transcript to:	
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Signature: _____	Date of Request: _____
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1. FAX to 808-521-2271 or
2. Email: [registrar@orientalmedicine.edu](mailto:registrar@orientalmedicine.edu) or
3. Mail to: ICAOM, c/o Registrar, 100 N. Beretania Street, Suite 203 B, Honolulu, HI 96817

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