**Swedish Institute**
College of Health Sciences

Acupuncture
Massage Therapy
Personal Training

# Duplicate Immunization Record Request

Date: ____________________

Your Name: ________________________ Telephone: __________________

Swedish Institute Student ID #: _____________________________________

Month/Year of Graduation: __________________________________________

Please check ONE:

❑ Will Pick-up

❑ Mail/Fax Copy to:

___________________________________________________________

___________________________________________________________

Signature: _____________________________________________________

**The fee for duplicate records is $10.**

**NOTE:** We keep records for 6 years from the time of graduation or withdrawal.

For office use only

Paid _____________ Type of payment: ☐ cash ☐ check #________ ☐ credit card

# of forms ____________ Date sent ______________