# REQUEST FOR ACADEMIC TRANSCRIPTS

Complete Section 1 of this form and then send the form to the school where you completed your nursing education. If you studied at more than one school, send a completed form to each school. **Your school must complete Section 2 and then send the completed form directly to SpanTran by email or courier. SpanTran will not accept completed forms sent by you to SpanTran.**

## SECTION 1: APPLICANT COMPLETE THIS SECTION

**1. YOUR CURRENT NAME**

_____

Family name(s) First name Other names

**2. YOUR NAME WHEN YOU WERE A STUDENT**

_____

Family name(s) First name Other names

**3. DATE OF BIRTH** _____ 4. **SPANTRAN NUMBER** (if known) _____

month / day / year

**4. NAME OF NURSING SCHOOL** _____

**5. DATES OF ATTENDANCE** from _____ to _____

month / day / year month / day / year

**6. DATE OF GRADUATION OR COMPLETION OF STUDIES** _____

month / day / year

**7. YOUR SIGNATURE** _____ **8. DATE** _____

month / day / year

## SECTION 2: NURSING SCHOOL COMPLETE THIS SECTION

**1. NAME OF SCHOOL** _____

**2. SCHOOL WEBSITE ADDRESS** _____

**3. STUDENT'S DATES OF ATTENDANCE** from _____ to _____

month / day / year month / day / year

**4. STUDENT'S DATE OF GRADUATION OR COMPLETION OF STUDIES** _____

month / day / year

**5. NAME OF DIPLOMA AWARDED (in original language)** _____

**6. DATE DIPLOMA WAS AWARDED** _____

month / day / year

**7. LANGUAGE(S) OF INSTRUCTION** _____ **TEXTBOOK LANGUAGE(S)** _____

**8. LENGTH OF NURSING PROGRAM** _____

**9. IS YOUR SCHOOL ACCREDITED OR RECOGNIZED BY THE GOVERNMENT**? ☐ Yes ☐ No

**10. NAME OF GOVERNMENT BODY THAT ACCREDITATED OR RECOGNIZED YOUR SCHOOL**

_____

**10. DATE YOUR SCHOOL WAS FIRST ACCREDITED OR RECOGNIZED** _____
month / day / year

**11. In the chart below, list the theoretical instruction hours and clinical practice hours this student completed. If your program does not have separate courses for any of the subjects in the chart, please estimate the hours.**

| SUBJECT | TOTAL THEORETICAL INSTRUCTION HOURS* | TOTAL CLINICAL PRACTICE HOURS |
|---|---|---|
| Adult medical nursing | | |
| Adult surgical nursing | | |
| Maternal-infant nursing (excluding gynecology) | | |
| Pediatric nursing | | |
| Psychiatric-mental health nursing (excluding neurology) | | |
| Neurology | | |
| Community health/public health nursing | | |
| Gerontology/geriatric nursing | | |
| Long term care nursing | | |
| Acute care nursing | | |
| Physical assessment | | |

*classroom instruction, laboratory hours, ward/clinical teaching hours

I confirm that the information listed above is complete and accurate.

**NAME OF PERSON COMPLETING THIS FORM** _____

**TITLE** _____ **DATE** _____
month / day / year

**SIGNATURE** _____

***RETURN THE FOLLOWING AS EMAIL ATTACHMENTS TO VERIFICATION@SPANTRAN.COM USING AN OFFICIAL INSTITUTIONAL EMAIL ACCOUNT:***

- This completed and signed form (incomplete forms and forms without a signature will not be accepted)
- Original language academic transcript or statement of marks that lists the student's courses, grades, and credits/hours
- Certified English translations (if available)

***EMAILS SENT USING AN OPEN SERVER EMAIL ADDRESS, SUCH AS YAHOO MAIL OR GMAIL, WILL NOT BE ACCEPTED.***

Completed forms can also be sent directly to SpanTran in a sealed envelope with your organization's stamp or seal on both the form and the envelope. Send the sealed envelope to:

**SpanTran: The Evaluation Company**
**2400 Augusta Drive, Suite 451**
**Houston, TX 77057 USA**