



TRANSCRIPT REQUEST FORM

OCEAN CITY HIGH SCHOOL

501 Atlantic Avenue

Ocean City, New Jersey 08226

Phone: (609) 399-1290

www.oceancityschools.org

Select One: COLLEGE APPLICATION: _____ SCHOLARSHIP APPLICATION: _____

Student Name: _____

College/Scholarship Name: _____ Date: _____

College/University/Scholarship Street Address:

City, State, Zip Code:

Application Deadline (allow 10 school days for processing): _____

Admission Plan: (Please select one for college applications only):

Early Decision ___ Early Action ___ Restrictive Early Action ___ Regular ___ Rolling ___ IDD ___

<u>Type Of Application</u> (circle one)	Common Application	Coalition Application	College Specific
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Counselor (circle one): Banks Kuhlberg Martin McDowell- Campo Tabano

Teacher Recommendations: 1. _____ 2. _____

Signature of Student

Date

Signature of Parent/Guardian

Date

Required if the student is under 18 years of age

OCHS Date Submitted: _____