HEALTH ENRICHMENT CENTER, INC.

DOCUMENTATION REQUEST FORM

Name : _____
(Last) (First) (Middle Initial)

Name at time of Graduation (If Different): _____

Address to send Documents to:

_____
(Street Address / Apt. No.) (City, State) (Zip Code)

Contact No: Cell:_____Home:_____

Email: _____

Requested Documents:

○ $10 ea B/W Transcript – Official Copy

○ $10 ea. B/W Copy of Graduation Diploma

○ $20 ea. Color Reproduction of Original Graduation Diploma

Paid by Check: _____AMT: _____DATE: _____

Paid by C/C: _____ EXP DATE: _____ SVC: _____

HEALTH ENRICHMENT CENTER
SCHOOL OF THERAPEUTIC MASSAGE

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Lapeer, MI 48446

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