Symbiosis Centre of Health Care

Distance Education Programs

Senapati Bapat Road Pune- 411004

Request for Transcript

(For academic year 2007 onwards)

1. Name of the candidate: _____
2. Program name: 1. _____

   2. _____
3. Roll no: 1._____ 2._____
4. Address: _____
5. Contact no: _____ 6. Email id: _____
7. Reason for requirement of transcript:_____

   _____

- Charges per transcript set is **500/-**

  Payment mode:

  1) Enclose Demand Draft No._____ Bank_____ dated_____ for Rs._____
  (Kindly draw a D.D.in favour of "Symbiosis Centre of Health Care", payable at Pune)

  2) Electronic payment by RTGS/NEFT:
  A/C Name Symbiosis Centre of Health Care, A/C no. 60052677905
  Bank of Maharashtra, S.B. Road Branch, Pune, IFSC code- MAHB0001261
  Please mention UTR/UTN number and attach acknowledgement receipt.

  You can also make online payment, please visit our website www.schcpune.org

Note: Please forward the scanned copies of Mark list, Diploma and Certificate to info@schcpune.org

Signature of Candidate:
Date: