



New York Library Association

The Voice of the Library Community

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CTLE TRANSCRIPT REQUEST FORM

Your transcript will be mailed to the address you provide below.
By submitting this form, you verify that the information provided is accurate
reflection of your participation.

STAFF USE ONLY
DATE RECEIVED:
APPROVED:
DATE ISSUED:

Participant Name:

Date of Birth: (MUST include month, day and year)

Last FOUR of Social Security Number:

Address:

City: State: Zip:

Table with 4 columns: DATE, PROGRAM / WORKSHOP TITLE, SPEAKER, DURATION*. Includes a row for TOTAL # OF CONTACT HOURS.

*Please list duration in hours, represented as a decimal. e.g. 90 minutes would be 1.5.

Applicant Signature: Date: