Student Information

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: |  | Student ID #: |  | |
| Address: |  | Phone number: |  | |
|  |  | DOB: \_\_\_\_\_\_\_\_\_ | |  |

Semester for which Tuition Appeal is Requested: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize the release of any medical information necessary to process this Tuition Appeal.

|  |
| --- |
|  |

Student Signature Date

**Student do not write below this line or your appeal will be denied.**

**MEDICAL OFFICE USE ONLY**

**Form must be completed in full. If blank spaces exist below, the appeal will be returned or denied.**

|  |  |  |
| --- | --- | --- |
| Medical Professional Name |  |  |
| Medical Specialty |  |  |
| Medical License # |  |  |
| Medical Office Phone |  |  |
| Medical Office Address |  |  |

**Briefly describe below, in the lines provided, your medical opinion of how the student’s caregiving duties impacted their ability to regularly attend courses:**

|  |
| --- |
|  |
|  |
|  |
|  |

Circle patient relationship to student: Parent Sibling Child Spouse Grandparent

Would this condition have affected the student’s ability to participate in on campus courses: ( ) Yes ( ) No

Would this condition have affected the student’s ability to participate in online courses: ( ) Yes ( ) No

If YES, please indicate the time period that the student would have been unable to participate:

From\_\_\_\_/\_\_\_\_/\_\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Date Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Professional Signature (Required) Date (Required) Physician Office Stamp (Required)