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.

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| --- |
|  |

Student Signature Date

**Student do not write below this line or your request 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 condition prevented them from**

**attending school.**

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|  |
|  |
|  |

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)