EMERGENCY TUITION ADJUSTMENT REQUEST

PLEASE PRINT

Student Name _____ CSU ID# _____

Street Address _____ Daytime Phone # _____

City, State, Zip Code _____ Semester / Year of Request _____

Email Address: _____

Medical Emergencies, Medical Conditions or Death must occur after the start of the semester for which the refund is requested.
PRE-EXISTING MEDICAL EMERGENCIES OR MEDICAL CONDITIONS ARE NOT GROUNDS FOR A REFUND.
Tuition adjustments for the same or a similar Medical Condition will only be considered ONCE during a student's entire academic history with CSU.

Illegible, incomplete forms or late requests will not be considered. Original documents must be submitted. Faxes or copies will not be accepted.

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To request an emergency tuition adjustment, I understand and agree that I must officially withdraw from ALL courses, complete and sign this form and send this form and all requested supporting documentation to: The Emergency Tuition Adjustment Committee / Cleveland State University / 2121 Euclid Ave Law Library 017 / Cleveland OH 44115.

I hereby submit my request for an emergency tuition adjustment. I have read and completed this form in its entirety and understand the decision of the Emergency Tuition Adjustment Committee is final. I understand that my financial aid award package may be affected as a result of this adjustment. The decision of the committee will be emailed to the address above.

Student's Signature: _____ **Today's Date:** _____

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PHYSICIAN'S AFFIDAVIT of a MEDICAL EMERGENCY OR MEDICAL CONDITION

The following affidavit is only for the purpose of establishing the eligibility of the above student to obtain an adjustment of the semester's tuition fees only.

☐ *1A. For the Medical Emergency or Medical Condition of the Student named above:*

I certify that my patient (name) _____ has experienced a Medical Emergency or has been diagnosed with a Medical Condition which renders him/her unable to attend classes at Cleveland State University.

☐ *1B. For the Medical Emergency of Medical Condition of the About Student's Immediate Family*

I certify that my patient (name) _____ who is the (relation to student) _____ has experienced a Medical Emergency or has been diagnosed with a Medical Condition and is, therefore, in need of continuous nursing or other similar services by the above student.

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☐ *2.* I am legally authorized to practice medicine/osteopathy/psychiatry in the State of _____. I declare under the penalties of perjury under the laws of the State of Ohio and the United States of America that the foregoing is true and correct.

My patient's Medical Emergency/Condition is: _____.

My patient's Medical Emergency or Condition began on (date): _____.

Recovery to the extent that my patient could attend classes at CSU will take _____week(s).

Physician's Signature: _____ State License Number: _____

Physician's Name (printed): _____ Date: _____

Address: _____ Phone Number: _____

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☐ *3. Death of Parent, Guardian, Spouse, Child or Sibling of the Student named above:*

I have attached an official death certificate and evidence of the familial relationship between deceased and the student named above.

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ETAC Use Only: ☐ *Denied* ☐ *Approved* *Date:* _____ *Reason:* _____

Revised December 9, 2010