EMERGENCY TUITION ADJUSTMENT REQUEST

This form must be submitted within 45 days of the end of the term for which the adjustment is being requested. Deadlines for submission are as follows:

Fall Semester ±January 31 st
Spring Semester ±June 30 th
Summer Semester ±September 30 th

PLEASE PRINT ALL INFORMATION

Student Name ____________________ CSU ID# ____________________

Daytime Phone # ____________________ Semester / Year of Request ____________________

Street Address ____________________

City, State, Zip Code ____________________

Email Address: ____________________

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Medical Emergency or Death must occur after the start of the semester for which the refund is requested.

Pre-existing medical conditions are NOT grounds for a refund unless there has been a serious complication .

Tuition adjustments will only be considered ONCE G X U L Q J D V W X G H Q W ¶V H Q W L U H D F D G H P L F career with Cleveland State.

officially withdraw n from ALL courses

- ☐ I have complete d and sign ed this form
- ☐ I have enclosed a copy of a death certificate and proof of the familial relationship (if section 1 is relevant)
- ☐ My physician has complete d page 2 of this document in its entirety
- ☐ Students may submit a personal statement documenting the impact of their medical emergency
- ☐ Send this form and all supporting documentation to:

  Emergency Tuition Adjustment Committee
  Cleveland State University
  2121 Euclid Ave ±BH114
  Cleveland , OH 44115

I understand that I will NOT receive a refund if I utilized Financial Aid funds to assist in addressing my account balance. Loan funds are returned to the originating lender to reduce my educational financial debt. I understand that I may lose eligibility for tuition-based Grants / Scholarships.

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

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The following affidavit is for the purpose of establishing the eligibility of the above student to obtain an adjustment of the V H P H V without expenses.

☐ 2A. 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 for the semester specified above.

☐ 2B. For the Medical Emergency or Medical Condition of the Above Named 6WXGHQW¶V ,PPHGLDWH)DPLO

I certify that my patient (name) _____ who is the _____ (relation to the 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 provided exclusively by the above named student.

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☐ 2C. 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:

0\ SDWLHQW¶V 0HGLFDO (P(please document ICD-10 Code)Q LV

_____ ICD10 Code: _____

Dates of hospitalization and/or course of treatment:

_____

Symptoms include:

_____

The functional limitations resulting from this condition or medical emergency include:

_____

_____

If as diagnosed prior to the

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Revised

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