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 31st
Spring Semester – June 30th
Summer Semester – September 30th

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 for the same or a similar medical condition will only be considered ***ONCE*** *during a student's entire academic career with Cleveland State.*

Illegible, incomplete forms or late requests will not be considered.

Original documents must be submitted. Faxes or copies will not be accepted.

This is a request to adjust tuition ONLY. The University does NOT adjust other semester incurred fees (material fees, UPass, etc.)

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To request consideration for an emergency tuition adjustment, I understand and agree that:

- ☐ **I have officially withdrawn from ALL courses**
- ☐ **I have completed and signed 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 completed and signed this document (if section 2 is relevant)**
- ☐ **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 - UN453
  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 mailed to the address listed above.

Student's Signature: ____ **Today's Date:** ____________________

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☐ *1. 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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Students completing section 1 above are not required to complete the second page of this request

~~~~~ ALL OTHER STUDENTS, PLEASE COMPLETE SIDE 2 ~~~~~

PLEASE PRINT CLEARLY

PHYSICIAN'S AFFIDAVIT of a MEDICAL EMERGENCY OR MEDICAL CONDITION

The following affidavit is for the purpose of establishing the eligibility of the above student to obtain an adjustment of the semester's tuition 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 Student's Immediate Family:*

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:

My patient's Medical Emergency/Condition is **(please document ICD9 Code):**

____ **ICD9 Code:** _______________

Dates of hospitalization and/or course of treatment:

____

Symptoms include:

____

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

____

____

If condition was diagnosed prior to the start of the term, what situation (change of circumstance) occurred during the specified term to prevent the student from attending?

____

____

How has this condition prevented the student from attending classes for more than a week?

____

____

Other comments:

____

____

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: ______________________