

TUITION REFUND APPEAL

INSTRUCTIONS: Tuition refund appeals are granted only in cases of rare and extreme circumstances and are not granted for failure to cancel, nonattendance, or employment. Before completing this form, you should meet with an advisor to discuss options, including taking incompletes in your courses instead of seeking a refund. If you decide to proceed with the appeal process, you must:

- Cancel courses before submitting this form;
- Complete Sections A through C below;
- Attach a personal statement that fully describes the circumstances that led to your withdrawal;
- Attach the required supporting documentation; and
- Submit this information to any One Stop center listed below.

If you have, or think you have, a disability related to this tuition refund appeal, consult with the Disability Services Office at 612-626-1333 or 180 McNamara Alumni Center prior to the completion of this form. If your appeal is approved, W (for Withdrawal) will remain on your academic record for each course. Undergraduates subject to the 13 credit policy must have an approved reduced credit load exemption from their college office before submitting this appeal. If you are an international student, contact International Scholar and Student Services, 190 Humphrey Center, before submitting this form.

The decision regarding your appeal will be mailed to you in approximately two to three weeks. Decisions are not available over the phone or by e-mail. Questions regarding this form or the appeal process can be directed to any One Stop center listed below.

DEADLINE: Your appeal must be received no later than August 31 of the academic year for which you are submitting the appeal because that is the end of the fiscal year. Accounting practices and compliance with regulations restrict our ability to process tuition refund appeals beyond the end of the fiscal year.

SECTION A: Student Information				
student name: last	first	middle	telephone	student ID
current address			city	state zip code
term/year of cancellation <input type="checkbox"/> fall 20____ <input type="checkbox"/> spring 20____ <input type="checkbox"/> May/summer 20____		college (CLA, CCE, etc.)	list course(s) canceled	

SECTION B: Reason for Appeal. Please check box for reason you are appealing and attach a personal statement regarding your reason for appeal, as well as the required documentation listed in the box below. Any documentation you provide is protected by Family Educational Rights and Privacy Act (FERPA) and Health Insurance Portability and Accountability Act (HIPAA).

<input type="checkbox"/> Medical	Your physician must complete the medical supplement on the next page and you must sign the authorization for release of medical information on that page.
<input type="checkbox"/> Death in immediate family	Copy of death certificate required.
<input type="checkbox"/> Military activation	Copy of military activation orders.
<input type="checkbox"/> Academic advisement	Letter on University stationery from college office or adviser indicating that incorrect information was given by a University representative.

SECTION C: Student Certification	
<input type="checkbox"/> I am not receiving financial aid for the term/year listed in Section A. (Financial aid includes loans, grants, scholarships, tuition benefits, and fellowships.) <input type="checkbox"/> I am receiving financial aid for the term/year listed in Section A. NOTE: If your circumstances require you to withdraw/drop from all courses, you are encouraged to contact a One Stop Counselor and your academic adviser so your decision will be based on a clear understanding of the consequences of withdrawing from courses. Questions may be directed to any One Stop center, below. I understand that in most cases retroactively canceling courses will result in being billed for financial aid that has been disbursed based on my original enrollment.	
Please note that any approval resulting in a reduction or removal of the student services fee or the University-sponsored Health Benefit plan will make you liable for all Boynton Health Service clinic charges and any outside health insurance claims.	
By signing this form, you are certifying that the information you provided is true. Misrepresentation of facts or documentation may be sufficient cause, in and of itself, for automatic denial of this appeal and may be in violation of the Student Conduct Code. If you have read and understood the statement above, sign and date the box below.	
Student signature	Date

for office use only		
approved? <input type="checkbox"/> yes <input type="checkbox"/> no	results of decision	
term/year	by	date

One Stop Student Services Centers



200 Fraser Hall
106 Pleasant St SE
Minneapolis, MN 55455-0422
612-624-1111
fax: 612-625-3002

130 Coffey Hall
1420 Eckles Ave
St Paul, MN 55108-6054
612-624-1111

130 West Bank Skyway
219 19th Ave S
Minneapolis, MN 55455-0427
612-624-1111

To request this form in an alternative format, please contact the Disability Services Liaison at 612-625-9578. The University of Minnesota is an equal opportunity employer and educator.

TUITION REFUND APPEAL MEDICAL SUPPLEMENT

INSTRUCTIONS FOR PHYSICIAN: This form is to be used to help the student with documentation for an exception to the University of Minnesota's tuition policy. When completing this form, you will be asked to rate conditions on a scale of mild, moderate, or severe. Please use these ratings to indicate the usual state of severity of the conditions during the illness period. Mild is intended to indicate impairment in functioning greater than would be expected for a college/university student, leading to some impairment in studying and /or missing of classes. Moderate indicates further impairment in functioning that is not excessive or extreme. Severe indicates extreme difficulty in functioning and complete inability to attend class or study. If additional space is needed, attach a separate letter on letterhead providing further information.

student name: last	first	middle	student ID
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To be completed by physician/medical professional			
Patient was seen for medical condition on (list all dates):			
List your diagnosis:			
Length of treatment:			
Was the student physically/emotionally incapable of attending classes during the term of the illness? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Rate the severity of how the illness impacted the student's daily functioning during the term of the illness: <input type="checkbox"/> Mild (less than 2 weeks) <input type="checkbox"/> Moderate (2-6 weeks) <input type="checkbox"/> Severe (more than 6 weeks)			
List specific symptoms and how they prevented the student from attending class(es):			
Extent of the illness or injury as it relates to the student's ability to participate in class: <input type="checkbox"/> Hospitalization (including day hospitalization) required (from _____ to _____) <input type="checkbox"/> Confined to bed (from _____ to _____)			
If this condition is a continuation of a prior condition, did the student suffer a relapse, have complications, or require a change in medication that affected her/his ability to attend classes: If yes, explain and give the date this was diagnosed:			
Rate how the student's illness affected the following daily functions:			
Ability to concentrate:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe <input type="checkbox"/> Not applicable
Ability to sleep:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe <input type="checkbox"/> Not applicable
Ability to attend class or study:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe <input type="checkbox"/> Not applicable
Energy level:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe <input type="checkbox"/> Not applicable
Other _____:	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe <input type="checkbox"/> Not applicable
Did you recommend ongoing treatment/therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often is/was the required treatment: <input type="checkbox"/> Daily <input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____		
When do you believe the student can/could resume daily activities, including attending class(es)?:			
Other comments pertinent to the student's circumstances:			

By signing this form, you are certifying that the information you provided is true to the best of your knowledge.

Name/title	Date
Signature	Name of service provider/hospital/clinic Phone number

Signature of student authorizing release of medical information.

Student signature	Date
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