UNIVERSITY OF MINNESOTA

TUITION REFUND APPEAL

DIRECTIONS—Tuition refund appeals are granted only in cases of rare and extreme circumstances and are not granted for failure to cancel, nonattendance, or employment. Your appeal must be received **no later than August 31 of the academic year for which you are submitting the appeal.** Accounting practices and compliance with regulations restrict our ability to process tuition refund appeals beyond the end of the fiscal year. You should meet with an advisor to discuss options, including taking incompletes in your courses instead of seeking a refund.

If you have already completed a Medical Supplement as part of your Academic Policy Petition for these courses, you do not need to complete page 3 and should submit that Medical Supplement.

Required actions

In order to proceed with the appeal process, use the checklist below to ensure you complete all required actions. The process **cannot continue** without completing the following actions:

- ❒ Withdraw from courses before submitting this form by contacting your college or academic adviser.
- ❒ Complete parts A through D on page 2.
- ❒ Attach a personal statement that fully describes the circumstances that led to your withdrawal.
- ❒ Attach the required supporting documentation listed on page 2 of form.

You must consult another University office if:

- ❒ you have, or think you have, a disability related to this Tuition Refund Appeal. Consult the Disability Services Office (612-626-1333 or 180 McNamara Alumni Center) before submitting this form.
- ❒ you were enrolled on the University-sponsored Student Health Benefit Plan during the semester you are appealing. Consult the Office of Student Health Benefits (N323 Boynton Health Services) before submitting this form.
- ❒ you utilized dining, bookstore or housing services for the semester you are appealing. Contact them directly as this appeal is only for tuition and fees.

Consequences of an approved appeal

There are consequences of receiving a tuition refund for your courses. Read the following consequences carefully before submitting this form.

Financial aid

By retroactively canceling courses, you may be billed for financial aid that was disbursed to you based on your original enrollment.

Your academic record

Regardless of the appeal decision, a grade of 'W' (for withdrawal) will remain on your academic record for each course.

Health insurance coverage

If you receive health coverage through the University-sponsored Student Health Benefit Plan and/or receive services at Boynton Health Service, you may lose your coverage and become liable for all services paid by the Plan and/or all Boynton Health Service charges retroactive to the beginning of the term. Contact the Office of Student Health Benefits at 612-624-0627 or umshbo@umn.edu with any questions prior to submitting this appeal.

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TUITION REFUND APPEAL

Return form to a One Stop Student Services location:

–East Bank–
University of Minnesota
333 Robert H. Bruininks Hall
222 Pleasant St SE
Minneapolis, MN 55455-0239
612-624-1111
fax: 612-625-3002

–St. Paul–
University of Minnesota
130 Coffey Hall
1420 Eckles Ave
St Paul, MN 55108-6054
612-624-1111
fax: 612-626-0008

–West Bank–
University of Minnesota
130 West Bank Skyway
219 19th Ave S
Minneapolis, MN 55455-0427
612-624-1111
fax: 612-626-9129

To ensure privacy online, open in Adobe Reader (free at Adobe.com). Please add the required signature(s) in blue or black ink.

PART A. Student information

Student name (last, first, middle initial)	Phone (include area code)	University ID

Current address (city, state, ZIP code)	Email address

Term/year of cancellation	College (e.g., CLA, CCE)	List course(s) canceled
❒ fall 20___ ❒ spring 20___ ❒ May/summer 20___		

PART B. Reason for appeal

Please check the box to indicate why you are appealing. **ATTACH** any required documentation below.

❒ Medical	Your physician must complete the medical supplement on the next page. You must sign the authorization for release of medical information on that page. Attach any additional documentation if necessary.
❒ Death in immediate family	**ATTACH** copy of death certificate.
❒ Military activation	**ATTACH** copy of military activation orders.
❒ Academic advisement	**ATTACH** letter on University stationary from your college office or adviser indicating that incorrect information was given by a University representative.

PART C. Personal statement

The tuition refund appeal committee requires that all students submit a personal statement describing their situation and why they are requesting a refund of tuition. Please **ATTACH** this to the appeal.

PART D. Student certification

1. Are you receiving financial aid for the term/year listed in PART A? ❒ Yes ❒ No

NOTE: Financial aid includes loans, grants, scholarships tuition benefits and fellowships. By receiving a refund of your tuition you may lose eligibility for aid you have already received which would result in a mandatory repayment of these funds. Please contact One Stop if you have any questions regarding this process.

2. Have you visited Boynton Health Services during the term listed? ❒ Yes ❒ No

NOTE: Any approval that results in the reduction or removal of the Student Services Fee and/or University Student Health Benefit Plan will make you liable for payment of all Boynton Health Service charges retroactive to the beginning of the term. Please contact Boynton if you have specific question about these charges.

3. Are you using the Student Health Benefit Plan for the term listed? ❒ Yes ❒ No

4. Have you previously received an approved Tuition Refund Appeal? ❒ Yes ❒ No

NOTE: Multiple appeals for the same or similar reasons will not be approved.

By signing this form, you certify the information you provided is true. Misrepresentation of facts may be sufficient cause for automatic denial of this appeal and may be in violation of the Student Conduct Code. If you have read and understood all of the above statements, please sign and date the box below:

Student signature	Date

office use only

approved? ❒ yes ❒ no term/year

processed by Staff Initials: _____ date: _____

OTR241

To request copies of this form in an alternative format, please call a Disability Resource Center liaison at 612-625-9578. The University of Minnesota is an equal opportunity employer and educator. This form is printed on paper made from no less than 20 percent post-consumer waste.

Please recycle.

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MEDICAL SUPPLEMENT

INSTRUCTIONS—This form assists students in providing documentation of a medical or disability condition when petitioning for an exception to a University of Minnesota policy. This form must be completed by the medical provider or by Disability Services if the student is currently registered with and has provided medical documentation surrounding their condition to Disability Services. If additional space is needed, please attach a separate letter on letterhead. The intent of this form is to specify dates and impact of medical or disability condition.

The University reserves the right to verify the authenticity of any information provided on this form.

To ensure privacy online, open in Adobe Reader (free at Adobe.com). Please add the required signature(s) in blue or black ink.

PART A. Student information

Student name (last, first, middle initial)	University ID

Signature of student authorizing release of medical information required

Student signature	Date

PART B. Medical information

Completed by ❒ physician/medical professional or ❒ Disability Services *(check one)*

Physician/medical professional or Disability Services met or had contact with the student on (list all dates):

Is this medical condition/disability a continuation of a previous condition? ☐ yes ☐ no

If yes, (check all that apply)

- Is this a chronic condition? ☐ yes ☐ no
- Did the student experience a relapse? ☐ yes ☐ no
- Did the student experience complications? ☐ yes ☐ no
- Did a change in medication or treatment affect the student's ability to attend class? ☐ yes ☐ no

The duration of the condition or treatment that impacts/impacted the student's ability to participate in class because of the following:

❒ hospitalization (including day hospitalization) required (from _____ to _____)

❒ confined to bed (from _____ to _____)

The duration/symptoms of the condition or treatment that impacts/impacted the student's daily functions:

Beginning date of condition and/or treatment: _____

Ending or anticipated ending of condition and/or treatment: _____

When do you believe the student can/could resume daily activities, including attending class(es)?

List specific symptom(s) and how they prevented the student from attending and participating in class(es)?

Did the student's condition and/or treatment affect the following daily functions:

Condition and/or treatment	Yes	No		Condition and/or treatment	Yes	No
Ability to concentrate	☐	☐		Ability to study	☐	☐
Ability to sleep	☐	☐		Low energy level	☐	☐
Ability to attend class	☐	☐		Other: _____	☐	☐
Difficulty interacting with others	☐	☐		Other: _____	☐	☐

Other comments pertinent to the student's circumstances:

PART C. Certification

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