



# 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<sup>st</sup>**

**Spring Semester – June 30<sup>th</sup>**

**Summer Semester – September 30<sup>th</sup>**

## 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- I have officially withdrawn from ALL courses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.

\*\*\*\*\*

*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.

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: \_\_\_\_\_