Tuition Refund Appeal

https://www.stcloudstate.edu/srfs/_files/documents/billing/tuition-refund-appeal.pdf

Submission must include the following:

1. Tuition Refund Appeal
2. Written statement citing extenuating circumstances
3. Additional supporting documentation if applicable such as an instructor or advisor statement, the medical/psychological verification form, employer statement, copy of an approved registration petition, etc.

Submit the completed Tuition Refund Appeal with supporting documentation to:

SCSU Business Services, AS 123, 720 4th Avenue South, St. Cloud, MN 56301

Note: If you are registered for the course(s), you must withdraw or petition for a late withdrawal/drop prior to requesting a refund.

Questions may be directed to businessservices@stcloudstate.edu

Tuition Refund Appeal

ST. CLOUD STATE UNIVERSITY

SCSU ID _____ Phone (_____)_____

_____ _____ _____
(PRINT) First Name Middle Name Last Name

_____ _____ _____ _____
Local Address: Street City State Zip

Email: _____@_____ May we notify you via email? ☐ Yes ☐ No

Advisor's Name _____ Were you awarded financial aid for the term appealed? ☐ Yes ☐ No

FINANCIAL AID IMPLICATIONS: Financial Aid programs limit the allowable time to return Federal and State funds. Refund appeals ***must be submitted within 45 days of the end of the term for which a refund appeal is submitted. Summer term appeals must be no later than September 25 of the next academic year.*** Most students receiving Financial Aid will have all or a portion of any approved refund credited to their aid funding sources and may incur repayment obligations if any aid overage monies were received. If you are receiving financial aid, a tuition refund could reduce your grant, scholarship or loan. Please contact the Financial Aid Office if you have questions. ☐ ☐

If you are still on record as being registered for the course (either with an assigned grade or in the current semester) you must withdraw or petition for a late drop/withdrawal prior to requesting a refund. **Why was the withdrawal/drop deadline missed?**

Term/Yr of Appeal _____ List each course for which a refund is being requested AND the last date attended.

	Dept Ex ENGL	**Number** 191	**Last Date of Attendance**
1			
2			
3			

	Dept Ex ENGL	**Number** 191	**Last Date of Attendance**
4			
5			
6			

Did you talk to the instructor(s) about receiving an "Incomplete" so that you could finish the course(s)? ☐ Yes ☐ No **If not, why?**

The committee requires written documentation of reasons. This may include an instructor or advisor statement; employer statement if the issue is work related; medical/psychological verification form if medical or counseling related; approved registration petition or appeal if one has been processed. **I believe my appeal should be granted because:**

Signature: _____ Date: _____

Submit completed form with required documentation to SCSU Business Services, AS 123, 720 Fourth Ave S, St. Cloud, MN 56301

Office Use Only: Committee Recommendation: Approved ☐ Denied ☐ Tabled ☐

_____

_____

Signature of Committee Chairperson: _____ Date _____

SCSU is an equal opportunity/affirmative action educator and employer

_____

PRINT: First Name Middle Last

Student ID_____

Personal Statement Citing Extenuating Circumstances

Please write or attach typed statement describing the extenuating circumstances that occurred after the deadline that prevented you from meeting the registration deadline.

ST. CLOUD STATE UNIVERSITY
720 4th AVENUE SOUTH
ST. CLOUD, MINNESOTA 56301-4498

Student: If you cited medical or psychological issues as reasons for an academic appeal or other academic change, it is necessary to have your medical/psychological provider verify the extenuating circumstances that are cited in your request. It is not necessary to supply full medical records. The provider information on this form must be returned with your appeal or academic change request.

MEDICAL VERIFICATION FORM

FOR ACADEMIC APPEALS AND REQUESTS FOR ACADEMIC CHANGE

SCSU ID#: _____ Email: _____@stcloudstate.edu

_____ _____ _____
First Name Middle Name Last Name

COURSE(S) IMPACTED BY MEDICAL/PSYCHOLOGICAL CONDITION (Indicate academic year, semester or individual impacted courses):

☐ **Entire Semester: Term _____ Year _____**

	ID: Ex 000243	**Course Title**	**Dept** Ex ENGL	**Number** 191	**Sec** 01	**Credits** 4	**Term** SPRING	**Year** 2014
1								
2								
3								
4								

Return to (student check department):

☐ Academic Appeals & Probation
St. Cloud State University, CH210
720 4th Avenue South
St. Cloud, MN 56301-4498
Fax: (320) 308-5672
Email: aap@stcloudstate.edu

☐ Business Services
St. Cloud State University, AS123
720 4th Avenue South
St. Cloud, MN 56301-4498
Email: businessservices@stcloudstate.edu

☐ Office of Records and Registration
St. Cloud State University, AS118
720 4th Avenue South
St. Cloud, MN 56301-4498
Fax: (320) 308-2059
Email: registrar@stcloudstate.edu

☐ **Other:** Office _____
St. Cloud State University, _____
720 4th Avenue South
St. Cloud, MN 56301-4498
Fax: (320) 308- _____
Email: _____@stcloudstate.edu

Please sign and date this form which acknowledges that you give permission to your medical/psychological provider to furnish the required information below.

Student Signature: _____ Date: _____

PROVIDER: The student named above is requesting documentation for extenuating circumstances that have impacted their academic performance. The nature of the request and the permission to release information are at the top of this form. Please respond on your letterhead or fill out form on opposite side and attach business card. Return to office address indicated by student. Thank you.

Student's First Name	Student's Middle Name	Student's Last Name
_____	_____	_____

Provider Name: _____

Contact information: (Attach card or include letterhead) _____

Provider Signature: _____ Date: _____

This St. Cloud State University student is asking to withdraw from one or more classes or appeal an academic issue because of a medical/psychological condition for which you have treated them.

Please fill out the following portion of this form in its entirety to assist the student in the withdrawal process.

Medical/psychological condition (brief description-Submission of medical records not required):

_____

_____

_____

_____

_____

_____

Date of onset of condition: _____ Duration of condition: _____

Dates of visits for this condition: _____

- In your professional opinion would the above condition for which you have treated the student prevent a student from attending class sessions in a University setting? Yes ____ No ____
- Please identify the dates or duration for which attendance may be impacted: _____
- In your professional opinion would the above condition for which you have treated the student prevent completion of coursework in a University setting for the above time periods? Yes ____ No ____
- Please identify the dates or duration for which coursework may be impacted: _____
- In your professional opinion has treatment progressed to the point where resumption of coursework and attendance is a reasonable expectation for the student? Yes_____ No _____