

# 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Tuition adjustments will only be considered ONCE G X U L Q J D V W X G H Q W have withdrawn from Cleveland State H P L F

- officially withdraw n from ALL courses
- I have complete d and sign ed 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 complete d page 2 of this document in its entirety
  - 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 ±BH114  
Cleveland , OH 44115

I understand that I will NOT receive a refund if I utilized Financial Aid funds to assist in addressing my account balance. Loan funds are returned to the originating lender to reduce my educational financial debt. I understand that I may lose eligibility for tuition-based Grants / Scholarships.

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

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The following affidavit is for the purpose of establishing the eligibility of the above student  
to obtain an adjustment of the V H P H V With U 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 6 W X G H Q W ¶ V , P P H G L D W H ) D P L

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:

0\ SDWLHQW¶V 0HGLFDO (Please Print Name & DOB) \_\_\_\_\_ Q LV  
\_\_\_\_\_ ICD10 Code: \_\_\_\_\_

Dates of hospitalization and/or course of treatment:  
\_\_\_\_\_

Symptoms include:  
\_\_\_\_\_

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

If \_\_\_\_\_ as diagnosed prior to the \_\_\_\_\_