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 31st
- Spring Semester – June 30th
- Summer Semester – September 30th

PLEASE PRINT ALL INFORMATION

Student Name ____________________________________    CSU ID# __________________________
Daytime Phone # _________________________    Semester / Year of Request ______________________________
Street Address __________________________________________________________________________________
City, State, Zip Code _____________________________________________________________________________
Email Address: _________________________________________________________________________________

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.

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☐ I have officially withdrawn from ALL courses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: _______________

☐ 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

Revised November 2014
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: ____________________

Revised November 2014