

Caregiver of III Family Member Certification Form

for Refund Request (Tuition Appeal) Purposes

This form must be completed by a licensed medical professional. **Form and signatures cannot be typed.**Tuition Appeal will be denied and further disciplinary action may be enforced if this form is found to be forged.

Student Information: To be completed before submitting to medical provider	
Student Name:	Student ID:
Student Email:	Semester:
Patient Information: To be completed before submitting to medical provider	
Patient Name:	Date of Birth:
Patient Email:	Patient Phone:
Patient's Relationship to Student:	
I authorize the release of medical information necessary to process this Tuition Appeal.	
Patient Signature (if 18 or over) OR S tudent Signature (if caring for a minor)	
Medical Office Use Only: The student may not write in this box.	
Practice Name:	
Medical Professional Name:	
Medical Specialty:	Professional License #:
Medical Office Address:	
Office Phone and Email for verification:	
For a tuition refund appeal to be approved, the care of the patient must be medically necessary for a substantial period of time. Briefly describe the unforeseen caregiving duties that prevented the student from attending class(es).	
Please indicate the substantial time period that the student would have been unable to participate in classes.	
From: To:	<u></u>
Would the caregiving duties have affected the student's ability to participate in/complete in-person courses (Yes/No):	
Would the caregiving duties have affected the student's ability to participate in/complete online courses (Yes/No):	
Medical Professional Signature and Date (Required)	Physician Office Stamp (Required)