Primary Caregiver of Ill 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: _____

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)