

**Withdrawal/Tuition & Fees Appeals Committee
Appeal Cover Sheet**

Please print this form and attach it to your appeal.

Name: _____

Mailing Address: _____

City/St/Zip: _____

Student Identification Number: _____

Phone Number and Email Address: _____

Year and Semester of Appeal: _____

Form(s) of payment used: Cash Credit Card Check Financial Aid Payment Plan
(circle all that apply)

Instructions:

1. Describe the reasons for your appeal in no more than two typewritten pages and attach to this sheet along with the required supporting documentation. As a general rule, appeals should be submitted within 30 days of date of withdrawal.
2. Appeals requested due to medical reasons must include documentation from a physician, clinic or hospital including a specific diagnosis and dates of treatment, as well as statements indicating your ability to attend classes.

My signature below affirms that I understand the following:

1. Students are responsible for ensuring all supporting documentation is submitted with the initial appeals package. Incomplete appeals packages will not be reviewed until all supporting documentation has been received which might result in a delay of the final decision.
2. Adjustments to withdrawal dates and tuition & fee charges may impact financial aid eligibility, which may result in the need for students to return any financial aid that has already been refunded to them.
3. Committee meetings are held once each month. Appeals are heard in the order received and must be received no later than the last day of the month in order to be heard in the next month.
4. Submission of this package does not guarantee that your appeal will be granted.

Signature

Date

Mail your appeal package to the Office of Enrollment Management, Attn: Maria Machado, Salem State University, 352 Lafayette Street, Salem, MA 01970-5353. Following review, you will receive a letter or email notification indicating the disposition of your appeal.

Health Care Provider Verification Form

Return form to:
Salem State University
Enrollment Management
352 Lafayette Street
Salem, MA 01970
978.542.6243
FAX 978.542.6753

INSTRUCTIONS TO THE HEALTH CARE PROVIDER

In order to consider a petition for a waiver of tuition forfeiture fees, Salem State University requires documentation from a licensed Health Care Provider verifying a current condition that prevents the student from attending the University during this semester. Please provide the following information along with a signed piece of letterhead after the student/patient has completed the release consent at the bottom of this form.

Name of Student Patient _____
(Last) (First) (Middle)

Patient's Student Number _____

Description of Student/Patient's condition and how it prevents the student from attending the University.
(Attach additional sheets as necessary)

Date of first visit _____ When did you last examine the student? _____

I certify that, in my professional opinion, the above named student is currently unable to attend Salem State University during the _____ (semester) of _____ (year) due to the medical conditions described above.

Signature of Health Care Provider _____

Health Care Provider's name printed _____

Date _____ Health Care Provider's phone number _____

CONSENT TO RELEASE MEDICAL INFORMATION

I, _____, give my permission for my Health Care Provider to release information to Salem State University concerning my physical condition as it relates to my request for a waiver of tuition forfeiture fees.

Signature of Student

Date

Signature of parent or guardian (if student under the age of 18)

Date

Completion of this form does not guarantee a refund. The Refund Appeals Committee reviews all materials submitted and makes a recommendation for approval or denial of appeals.