REQUEST FOR SCHOOL OF MEDICINE MD PROGRAM EDUCATION FEE ADJUSTMENT
University of Missouri-Kansas City
Office of Registration & Records

DEADLINE FOR FILING A REFUND PETITION IS 30 DAYS PAST THE END OF THE TERM

This application is for (check only one): ❑ Summer 20_____ ❑ Fall 20_____ ❑ Spring 20_____

Name	Student ID number
Address	City, state ZIP
Telephone	E-mail address

INSTRUCTIONS: PLEASE BE SURE TO PROVIDE ALL REQUESTED INFORMATION AND ATTACH THE REQUIRED LEAVE OF ABSENCE FORMS WITH THIS FORM. THE SCHOOL OF MEDICINE REVIEWS ALL FEE ADJUSTMENT FORMS.

Please indicate each period for which you were enrolled for the semester indicated:

Summer	Fall	Spring
❑ Block 1	❑ Block 4	❑ Block 8
❑ Block 2	❑ Block 5	❑ Block 9
❑ Block 3	❑ Block 6	❑ Block 10
	❑ Block 7	❑ Block 11
		❑ Block 12
		❑ Block 13

Additional information: ____

____

____

By signing this form, I am affirming that I have reviewed UMKC's Request for School of Medicine Education Fee Adjustment Policy and understand the criteria for which adjustments are granted.
http://www.umkc.edu/registrar/procedures/petition-for-refund.asp

Student signature____ **Date** ______________
Return to: Council on Evaluation, UMKC School of Medicine, 2411 Holmes Street, Room M1-215. Fax: 816-235-6613

School of Medicine Representative Signature ____________________________ **Date**______________

For office use only

❑ Request more information: ____

❑ Denied Notes: ____

Processed by:____ Date: ____________________