

Westchester Community College

State University of New York

Medical Appeal Refund Request Form

***Please note all such information mandated by the college is treated as confidential and privileged.**

NAME: _____

Student ID: _____

ADDRESS: _____

TELEPHONE: _____

Email: _____

Semester applying for: (Please circle one) Fall /Spring / Summer Year _____

Personal Statement / Reason for Request:

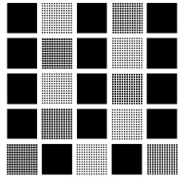
Signature

Date

**Mail to: Refund Committee % Health Service Coordinator @ Westchester Community College
75 Grassland Rd, Student Center , Room 112, Valhalla, NY 10595**

** This information may contain confidential health information and is only for the use of the individual or entity named.
The recipient is obligated to maintain the information in a secure and confidential manner.**

Fax to: Refund Committee % Health Service Coordinator @ 914-606-6423 or 914-606-8951



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Medical Appeal Refund Request Check List

- ✓ 1. Complete, sign and date the Medical Appeal Refund Request Form. A brief personal statement must be included.
- ✓ 2. Obtain a signed letter from your health care provider (Doctor, Physician Assistant or Nurse Practitioner) on professional letterhead. The letter must include the nature of the illness/diagnosis, dates of the condition and it's effect on the student's ability to attend classes during the semester for which the request is being submitted. Pre-existing conditions are not accepted unless unexpected circumstances occurred or symptoms exacerbated during the semester for which the appeal is requested.
- ✓ 3. Submit the Medical Appeal Refund Request Form & Medical documentation to:

**Refund Committee % Health Service Coordinator
Westchester Community College
75 Grassland Rd, Student Center, Room 112
Valhalla, NY 10595**

Or Fax Refund Committee % Health Service Coordinator

Fax: 914-606-6423 or 914-606-8951

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