**UCD STUDENT HEALTH SERVICE MEDICAL WAIVER REQUEST**

APPLICATION NO:\_\_\_\_\_\_\_\_\_\_\_

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| **UCD MEDICAL WAIVER REQUEST FORM** |
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| **APPLICANT INFORMATION** |
| Name: |  |
| Date of Birth: |  |
| Student Number: |  |
| Student Email Address: |  |
| Course: |  |
| Term Address: |  |
|  |
| Term Contact Number: |  |
| **HOME INFORMATION** |
| Home Address: |  |
|  |
|  |
| Home Contact Number: |  |
| Personal Email Address: |  |
| Name of Family Doctor: |  |
| Address of Family Doctor: |  |
|  |
| **UCD FINANCIAL MEDICAL WAIVER**  |
| Is this your first visit to the Student Medical Centre: | Yes :  |  No:  |
| If not please indicate your approximate number of visits to date this academic year \_\_\_\_ |
| Are you in receipt of a higher education grant: | Yes:  | No:  |
| Do you have a medical card: | Yes: | No:  |
| Please state the reasons for your application for financial medical assistance in this case: |

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| **UCD MEDICAL WAIVER REQUEST FORM** |
| Please outline current sources of income: |  |
| Please outline current expenditures: |  |
| Are you engaged in part time employment: | Yes:  | No: |
| Causes of financial difficulty (please tick appropriate box) |
| Bereavement:  | Illness:  | Accidents: |
| Unforeseen parental unemployment:  | Family Breakdown:  | Students who have family obligations(particularly child care costs)  |
| If other please specify: |
| **TERMS AND CONDITIONS** |
| The Medical Director will review this request and decide if the outstanding fees can be waived. If the request is accepted this will clear arrears only. |
| **SIGNATURE** |

Signature of applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_