**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: ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_