

TUITION REMISSION GRANT REQUEST

Quarter: _____

Date: ____/____/____

School: SOT / SOP / SIS

Name of Claimant: _____
Last First Middle

Student ID: G _____

AUTHORIZATION (Please Check One)

FTS Box #: _____

- Faculty
 Staff – Department: _____

CRN	Catalog #	Course Name	Units

- _____
(Supervisor's Signature)
 Relative of Employee

Total Units: _____

(Employee's Name / Department)

I have read the current Tuition Remission Policy and accept the terms and conditions.

Claimant's Signature: _____

Date: ____/____/____

DEADLINE: Cards should be returned to the Student Accounts Office by **Friday of the 2nd week of the quarter** in order to be considered for tuition remission.