



# APPLICATION FOR TUITION CREDIT FOR MEDICAL REASONS

To be completed by the student who has withdrawn from all classes due to a sudden medical emergency. (Not valid after week 10)

**I. To be eligible for consideration, applicants must complete each of the steps as indicated below:**

- Officially withdraw from all classes in the semester in question. This process must be completed with the Office of Enrollment Services. Withdrawal must be completed within the same semester for which you are requesting credit.
- Pay in full any remaining balance in your student account for the semester in question. If you have a balance due, your application for credit will be rejected.
- If you have received financial aid, your aid will be prorated based on the percentage of time you spent in class, and you may owe a balance.

**II. After completion of all of the above and within 21 days of your official withdrawal, complete this application and attach documentation from your physician that specifies the medical emergency.**

The physician’s documentation must include: diagnosis, treatment and dates of treatment, reason you are unable to continue your classes. This is intended to assist students who experience a sudden medical emergency. Non-emergency circumstances are assisted by the college withdrawal policies, and will not be considered in this process.

*Please note: all medical documents are confidential and maintained separate from the student’s academic record.*

**III. Please provide the following information:**

\_\_\_\_\_ Name (please print) \_\_\_\_\_ Student ID # \_\_\_\_\_

\_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Semester/Academic Year of withdrawal \_\_\_\_\_ / \_\_\_\_\_

Date you completed the official withdrawal \_\_\_\_\_

**IV. I understand that the tuition credit for which I am applying may be used, if approved, toward tuition upon return to Lehigh Carbon Community College within one year of the end of the semester in which I have withdrawn. I also understand that I will be notified in writing as to the last semester that this credit may be applied. I understand that this credit is not transferable to another party and will be cancelled if not used by the date specified.**

Student’s Signature \_\_\_\_\_ Date \_\_\_\_\_

**V. Attach the physician’s medical documents and submit to the Director of Enrollment Services, Schnecksville campus, AD 123. For more information, please call 610-799-1171.**

The College will not discriminate on the basis of race, color, sex, religion, ancestry, national origin, age, disabilities, veteran status, or sexual orientation in its educational programs, activities, admissions, or employment practices as required by applicable laws and regulations. For information regarding civil rights or grievance procedures or for information regarding services, activities, and facilities that are accessible to and useable by persons with disabilities, contact the Office of Human Resources. Students may contact the Office of Disability Support Services, LCCC, 4525 Education Park Drive, Schnecksville, PA 18078-2598, 610-799-2121. PERM33A-uu (2/13/07)



APPLICATION FOR TUITION CREDIT  
PHYSICIAN'S AFFIDAVIT OF MEDICAL EMERGENCY

*\*To be used by the student who has withdrawn from all classes due to a sudden medical emergency.*

RE: \_\_\_\_\_ Student ID \_\_\_\_\_  
Student Name

I hereby grant permission to my physician to release the requested information below to Lehigh Carbon Community College Office of Enrollment Services.

\_\_\_\_\_  
Student Signature Date

The purpose of this affidavit is to establish that the above referenced student was unable to attend, or successfully complete, classes at Lehigh Carbon Community College due to a sudden illness or accident.

I certify that \_\_\_\_\_ was in my care for medical treatment  
Patient Name  
from \_\_\_\_\_ to \_\_\_\_\_. The nature of the patient's illness/injury is:

DIAGNOSIS \_\_\_\_\_

TREATMENT \_\_\_\_\_

REASON PATIENT IS UNABLE TO ATTEND CLASS \_\_\_\_\_

I affirm that the patient's illness/injury required special care provided by \_\_\_\_\_ and in my opinion necessitated the student's  
Physician Name  
withdrawal from classes for the current term.

\_\_\_\_\_  
Physician Signature Date

\_\_\_\_\_  
Physician Name (please print)

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, and Zip code

\_\_\_\_\_  
Phone Number

Please note: all medical documents are confidential and maintained separate from the student's academic record. Documents can be faxed to the Enrollment Services Office at 610-799-1173 or mailed to Enrollment Services, 4525 Education Park Drive, Schnecksville, PA 18078.