I. Personal Information

Name: ___________________________________________ Student ID #: _____________________________
(last, first -- please print clearly)

Telephone: ______________________________________ Email: _________________________________
(area code + number)

II. Check all boxes below that apply

☑ Drop past refund deadline
☑ Refund past deadline

III. What are the reasons an exception should be made?

☑ ON A SEPARATE PIECE OF PAPER, please explain the circumstances regarding your request, including dates. (See Instructions below for additional documentation Requirements.)

IV. Required Signatures:

☑ Student: By signing below I certify that I have read the information on this form and that all statements on this form and all supplemental information submitted with this form are true.

______________________________ Date: ________________

☑ Instructor(s): ____________________________________________________________________________ Date: ________________

Approval recommended? ☐ Yes ☐ No

For drops, what is last date student attended? __________________________ (attach additional pages for more instructors)

Instructions

Changes must be requested prior to the end of the quarter in question. Return completed petition and supporting documentation to Kodiak Corner for review. The outcome of the petition will be communicated via email.

- **Drop course past deadline** - For military or medical reasons, provide documentation (see below). Instructors must give last date of attendance.

- **Refund past refund deadline**
  1. Medical: Severe and unexpected illness which began during the quarter and precludes any and all activity.
  2. Military: Call to active military duty. Include a copy of your orders showing the date that you were called to active duty.
  3. College administrative error. Describe the situation and provide any information that you feel would support your request (i.e. note from an advisor).

Official use only:

☑ Approved / ☐ Denied | Staff initials: ___________ Date: ___________ Comments:

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