UNIVERSITY OF WYOMING
STUDENT HEALTH SERVICE

STUDENT MEDICAL EXPENSES FUND APPLICATION

Name: _____ W#: _____

Amount of funds requested: $_____ Phone number: _____

Email: _____

Medical expenses for which you are unable to pay (provide documentation attached to this application). Please provide information regarding the exceptional circumstances that require additional funding (use back if needed):

_____

_____

_____

_____

I understand that if I receive money from the Student Medical Expenses Fund, I must use the funds for expenses associated with the medical situation I have identified above. I will also make an effort to contribute back to the Fund when I am able so that the Fund can provide similar assistance to other students in the future. I understand that this Fund is available to me once during my time at the University of Wyoming and I cannot apply again.

_____ _____

Applicant's signature Date

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LOAN APPROVED FOR $_____

_____ _____

Student Health Service Director's Signature Date

11/18