If you are a student at NIU, students may appeal for exception to reimbursement. You will be requested to fully complete and submit pages 2-3.

**If review of your health information is required:**
Complete the Student Application and Authorization (page 2). As you complete this paperwork, please keep the following in mind:

1. A licensed attending physician, Advanced Practice Provider (APN) or Certified Physician’s Assistant (PAC) must fully complete and sign the Licensed Provider Medical Documentation Form (page 3).

2. The documents (page 2 and 3) must be fully completed and received in its entirety by NIU Immunization Compliance and Records Office before a medical review begins. We will accept fax documents. We will also accept email: immunizationrecords@niu.edu. You may also submit all completed forms to:
   
   NIU  
   Immunization Compliance and Records Office  
   Health Services Building, Room 209  
   DeKalb, IL 60115-2828

3. This document or information form will not be disclosed to anyone outside of our department without authorization for Release of Information signed by you.

4. We will review your submitted information. This review is typically completed in approximately 3 to 5 working days after the fully completed and appropriately signed information is received.

5. The Provost Office will be notified as to whether your documentation Supports or Does Not Support your request. You should contact your College of Study/Provost Office in advance of submitting the attached documents to our office. Final outcome of your Exception to Reimbursement is determined by the Academic College.

6. If the medical information provided from your physician / provider is not sufficient, our office will notify you of this determination. You may submit additional, new medical information for the administrative provider to review.

7. Falsification of any of these documents will be a reported to the Office of Student Conduct for further action.

If you have questions, please contact us at: 815-753-9578, Monday – Friday 8 a.m.- 4:30 p.m.
Appeal for Exception to Reimbursement
Student Application and Authorization Medical Documentation

I am seeking a medical verification for tuition reimbursement for the semester and year identified below.

Name ____________________________________________ Z-ID # __________________

Address________________________________________________________________________

City __________________________________ State ___________ Zip Code ___________

Current daytime telephone number_________________________ Date of birth:_____________________________

Current Email Address:__________________________________________

Semester (circle one): Fall Spring Summer Interim Year _______________

GRADUATE:    UNDERGRADUATE:

I HEREBY REQUEST AND AUTHORIZE the appropriate designees of Northern Illinois University, DeKalb, IL 60115:

1. To verify the presence of an acute and/or prolonged, severe medical condition during the above semester to be forwarded to the PROVOST’S OFFICE or GRADUATE SCHOOL.

2. (Optional) The person/s listed below has my permission to discuss the status of my appeal (e.g., parent, spouse, etc.):

________________________________________________________________________

(Name of person and relationship to applicant)

I understand that I have the right to inspect and/or obtain a copy of the information prior to disclosure and that my refusal to authorize disclosure of this information will result in the following consequences: Denial of my request.

I may revoke this authorization at any time by written notification to Northern Illinois University, Immunization Compliance and Records Office. However, I understand revocation cannot be retroactive. I absolve and agree to hold harmless the individual or agency identified above, and the NIU Board of Trustees, together with its officers and employees, from any legal liability, claims or damages which may arise from the disclosure of this information. Unless revoked, this consent is valid until the request is completely processed.

Signature of applicant:________________________________________

Date:____________________________________
Student’s Full Name ____________________________________________ Z-ID# _____________________

Semester and Year of Request ________________________________ DOB ___________________

Please type or print the requested information in the space provided below and return this form with original signature to the address above. DO NOT FAX.

<table>
<thead>
<tr>
<th>1. DIAGNOSIS AND ICD – 10 CODE of the severe medical condition that requires a special housing and/or dining arrangement.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. For the above condition, indicate the: Date(s) of evaluation and f/u treatment during the past 6 months; Location of evaluation and f/u treatments (e.g., office, hospital OP, hospital IP, etc.); Nature/ purpose of each evaluation and/or treatment provided; Date of initial onset</td>
</tr>
<tr>
<td>3. Provide the specific medical findings, restrictions and/or other objective data that documents how the students class attendance or participation was impaired or obstructed during the above semester(s)</td>
</tr>
</tbody>
</table>

_____________________________________________________ ________________________________________
Signature of Attending Physician, Advanced Practice Nurse or Physicians Assistant - Certified

__________________________________________
Printed Name, Business Address, Telephone Number