**REFUND REQUEST**

**Reason for Request:**

# Graduation

**Withdrawal from University Exiting Employee**

**DATE**

**Other**

Please be Specific

# Account Holder’s Name:

**Campus ID # Phone #**

**Mail Refund To:**

Street or P.O. Box

City State Zip

# AMOUNT REQUESTED: $

*A refund check will be mailed to the address above within (15) working days. A $5.00 processing fee will be deducted from your account. The processing fee is waived for graduating students and exiting employees.*

Please sign here:

## Refund Authorization Signature of ID BUC$ Account Holder

**ID Office Use Only**

Refund Request Approved by:

ID BUC$ Balance before Refund $

Processing Fee $

Amount of Refund Check $

Processed by:

Date Processed:

ID BUC$ Balance after Refund $

Debit Account E110001-79990-25040-999 $

Credit Processing Fee to Account E758877 $

Please issue Check for the amount of: $

Approved By: Date: