Jacobs School of Medicine and Biomedical Sciences
University at Buffalo

Request to Amend Tuition Remission/Scholarship Verification

(Student Name)

Last Name: _____   First Name: _____   MI: _____   Person Number: _____

A. Original Information

Semester/Year: _____

Entity Code: _____   Account Number: _____

Academic Department/Unit Name: _____

B. Information to Change

FROM	TO
☐ 1. # of Graduate credit hours: _____	# of Graduate credit hours: _____
Scholarship Payment Amount: $ _____	Scholarship Payment Amount: $ _____
☐ 2. RF Account #: _____	RF Account #: _____

☐ 3. Please provide a brief description of why this change is needed:

_____

☐ 4. Delete the Tuition Scholarship   Reason:

_____

☐ 5. Stipend Amount: $ _____	Stipend Amount: $ _____
☐ 6. Date of Appointment Starting: _____	Date of Appointment Starting: _____
Date of Appointment Ending: _____	Date of Appointment Ending: _____

C. Authorization

_____   _____   _____
Funding Supervisor or Principal Investigator (Please Print)   Funding Supervisor or Principal Investigator Signature   Date

_____   _____   _____
Dean/Vice President (Please Print)   Dean/Vice President Signature   Date

_____
Dean's Entity Code

Last Updated: 7/2024