UNIVERSITY OF KANSAS MEDICAL CENTER
APPEAL TO THE FEE REASSESSMENT COMMITTEE

Date: ___________________________

Name	KU ID#
Mailing Address:	Daytime telephone #
	Evening telephone #
City, Street Zip	

A. I understand that, based on my submitted petition, I have been denied a fee reassessment.
B. I further understand that I have the right to appeal this decision.
C. I hereby, appeal this decision by requesting that my Petition for Fee Reassessment be reviewed by the Office of the Registrar, and if again denied, be presented to Appeal Committee for review.
D. I wish to present the items listed below as new and/or additional information for consideration (Use reverse side if necessary).

I certify that the information on this Appeal of Fee Reassessment is correct and that the information on my Petition for Fee Reassessment is still correct.

Student Signature _______________________________________ **Date** ___________________________

Return to: KUMC **Office of the Registrar, Mail Stop 4029, 3901 Rainbow Blvd., Kansas City, KS 66160.** If you have additional questions, please contact the Office of the Registrar at (913) 588-7055 or kumcregistrar@kumc.edu.