WESTERN CONNECTICUT STATE UNIVERSITY
Withdrawal/Refund Request
Division of Graduate Studies
Fax: (203) 837-8326

Name (Last)____________________________ (First)___________________________
Student I.D. # ___ ___ ___ ___ ___ ___ ___ ___
Address
Street                                                                                             City                                            State                Zip Code
Semester: ___ Fall ___ Spring ___ Intersession ___ Spring Break ___ Summer                   Yr:____
Student Status: ___ Graduate ___ Undergraduate

Course(s) to be dropped/withdrawn:

<table>
<thead>
<tr>
<th>5-DIGIT CODE#</th>
<th>DEPT.</th>
<th>COURSE#</th>
<th>SECTION#</th>
<th>COURSE TITLE</th>
<th>SEM HRS.</th>
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Reason for Drop/Withdrawal: ________________________________________________________________

_____________________________________                              __________________
Student Signature                                                                                                             Date

NOTE: Withdrawing from a course may have financial aid implications. Please consult with the Office of Student Financial Services before submitting this form.

____________________________________________________________________________________________________________

For Office Use Only:

Percentage of Refund_____  Amount of Refund ___________________________  Date Processed
Graduate Office ___________________________  Signature

11/11/13