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Course(s) to be dropped/withdrawn:

5-DIGIT CODE#   DEPT.      COURSE#  SECTION#   COURSE TITLE                     SEM HRS.
                _______  _______  _______        ________________________     ___
                _______  _______  _______        ________________________     ___
                _______  _______  _______        ________________________     ___
Reason for Drop/Withdrawal:  ______________________________________________
                                                                                   __________________
_______________________________________________________________________
                                                                                   Student Signature  Date
____________________________________________________________________________________________________________
For Office Use Only:

Percentage of Refund_____  Amount of Refund ____________________________  Date Processed
Graduate Office ___________________________  Signature
                                                                                   09/13/11