# WINONA STATE UNIVERSITY - REDUCED STUDENT FEE AUTHORIZATION

**TO BE COMPLETED BY STUDENT OR DEPARTMENT ADVISOR/INSTRUCTOR**

_____ **Semester** (Summer, Fall, Spring) **OR** 2 0 1 __ **Year** __ **Term** (1, 3, 5)

_____ Student's Last Name _____ Student's First Name __ __ __ __ __ __ __ __ Warrior ID #

| | | | | | |
|---|---|---|---|---|---|
| _____ Cr Hr | 0 0 __ __ __ __ Course ID# | __ __ __ __ Subj | __ __ __ __ Nbr | _____ Course Name | _____ Course Site (City/State) |
| _____ Cr Hr | 0 0 __ __ __ __ Course ID# | __ __ __ __ Subj | __ __ __ __ Nbr | _____ Course Name | _____ Course Site (City/State) |
| _____ Cr Hr | 0 0 __ __ __ __ Course ID# | __ __ __ __ Subj | __ __ __ __ Nbr | _____ Course Name | _____ Course Site (City/State) |

**PLEASE NOTE** – Reduced student fees include the **Union Facility Fee, Wellness Fee, Student Life Fee, Athletics Fee & Health Service Fee ONLY.** These fees will be reduced in half, **if the course(s) qualify**. All other fees at Winona State University are not reduced. Qualification requires that the course(s) be completed **beyond the 50 mile radius** from the Winona campus.

**REDUCED FEES DO NOT APPLY TO ONLINE COURSES OR IF YOU ARE ENROLLED CONCURRENTLY IN A WINONA OR ROCHESTER CAMPUS COURSE.**

**Please submit form to: WSU Department Advisor/Instructor**

**TO BE COMPLETED BY DEPARTMENT ADVISOR/INSTRUCTOR**

*This student is scheduled for the entire term at a location outside a 50 mile radius from the Winona State University campus and is engaged in the following activity:* *(check one)*

_____ INTERNSHIP _____ STUDENT TEACHING

_____ INDEPENDENT STUDY _____ MEDICAL TECHNOLOGY

_____ OTHER _____
Please specify

_____ **WSU Advisor/Instructor's Signature** _____ **Department** _____ **Date**

**Please return form to: Student Accounts, 225 Maxwell**

**Student Accounts/Accounts Receivable Office Use Only**

201__ Term #_____ Cr Hr $_____ Total Waived

9157 FACILITY USE FEE _____

9190 WELLNESS CTR FEE _____

9156 STUDENT LIFE FEE _____

9172 ATHLETICS FEE _____

9163 HEALTH SVC FEE _____ DATE _____ BY _____

REV 04/21/09