FEES REFUND FORM

Refunds for each term are dealt with separately and must be submitted to the School not later than 30 days after the end of the term to which they relate.

PART 1 – to be completed by the **Fee Payer and returned to the School**. If your request for a refund is for **15 consecutive days or more**, please arrange for **PART 2 overleaf** to be completed by the Medical Practitioner attending the pupil.

Please note: Medical fees borne by the School or Fee Payer in preparing a request for a refund are excluded.

PART 1

Name of Pupil: ______________________________ Date of birth: ______________

Name of School: ______________________________ Postcode of School: ______________

Name and full address of Fee Payer: ______________________________

____

____

______________________________ Postcode: ______________

Details of illness/condition or reason for absence: ______________________________

____

____

____

From: ______________________________ To: ______________________________

(first day of incapacity) (last day of incapacity)

Was the absence of the Pupil for any sickness, condition or injury that the Fee Payer, parent, legal guardian or Pupil was aware of and has received treatment or advice for (including regular or routine examinations or consultations to monitor the condition) in the 12 months prior to being covered on this scheme at this School? YES ☐ NO ☐

If YES, please provide details: ______________________________

____

____

Signature of Fee Payer: ______________________________ **Date:** ______________

PART 2 – to be fully completed by the **Medical Practitioner. Upon completion of this section the form should be forwarded to the fee payer for submission to the school.**

Are you the patient's usual doctor? YES ☐ NO ☐

Please give full details of injury/illness:

First day of incapacity: ______ Last day of incapacity: ______

When did the patient first receive medical attention for this condition? ______

Has the patient ever suffered with this or any similar condition before the present episode? YES ☐ NO ☐

If YES, has the patient been free of all related symptoms for the last 24 months? YES ☐ NO ☐

If NO, please give details including dates, treatment and consultation(s): ______

Please use validation stamp or complete in BLOCK CAPITALS:

Name: ______

Qualification: ______

Address: ______

Postcode: ______

Telephone number: ______

Stamp:

Signature: ______ **Date:** ______