

# 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:

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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): \_\_\_\_\_

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**Please use validation stamp or complete in BLOCK CAPITALS:**

Name: \_\_\_\_\_

Qualification: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Postcode: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Stamp:

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_