UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

AGE 60 PLUS TUITION WAIVER APPLICATION FORM

☐ Graduate School ☐ Health Professions ☐ Medicine ☐ Nursing ☐ Pharmacy ☐ Public Health

1. Name: _____
   Last First Initial

2. Program of Study: _____

3. Waiver requested for: _____ Term and _____ Year
   (fall, spring, summer)

4. Current Legal Address: _____
   Street and Number

   _____ _____
   City County State Zip Code Phone

5. Permanent Legal Address: (if different) _____
   Street and Number

   _____
   City County State Zip Code Phone

6. Last 4 digits of Social Security Number _____ OR Student ID number: _____

7. Please provide the following documentation showing proof of age to establish eligibility for tuition waiver. This is only required for initial approval:

   ❑ State of Arkansas Driver's License

   OR

   ❑ Birth Certificate

SIGNATURE: *By signing below, I affirm that the information given is complete and accurate.*

Signature _____ Date _____

SUBMIT THIS FORM WITH PROOF OF AGE TO THE **OFFICE OF THE REGISTRAR**
Fax to 501-526-3220 ■ Email to registrar@uams.edu ■ Send via standard mail, Slot 767
■ Drop off at Office of the University Registrar at 4301 W. Markham, Building 2

Office Use Only ❑ This student has presented a valid Arkansas driver's license . **– OR -**
❑ This student has presented a birth certificate.

Date: _____ Initials: _____