

UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

**BORDER COUNTY OUT OF STATE TUITION WAIVER
APPLICATION FORM**

Date: _____ Semester / Year Applying For: _____

Graduate School Health Professions Medicine Nursing Pharmacy Public Health

1. Name: _____
Last First Initial

2. Current Legal Address: _____
Street and Number

_____ City County State Zip Code Phone

3. Local Address: (if different) _____
Street and Number

_____ City County State Zip Code Phone

4. Last 4 digits of Social Security Number _____

5. Please provide your tax status as either dependent or independent:

I am independent and was NOT claimed on my parent(s) income taxes last year.

I am a dependent and was claimed on my parent/guardian(s) income taxes last year. → IF YOU ANSWERED YES HERE, PLEASE ANSWER QUESTION 6

Provide the following information on for the taxpayer who claimed you as a dependent last year:

6. Name _____ Relationship _____

Current Address _____

City/State/Zip _____ Phone _____

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

Signature _____ Date _____

SUBMIT THIS FORM WITH SALARY/WAGE DOCUMENTATION TO THE **STUDENT FINANCIAL SERVICES OFFICE**

Fax to 501-686-8002 ■ Email to StudentFinancialServices@uams.edu ■ Send via standard mail, Slot 758

■ Drop off at the Student Financial Services offices, Administration West, CHP 6A

Office Use Only This student has presented valid salary/wage documentation.

This student's tuition waiver is eligible for reimbursement from the state's reimbursement fund.

Date: _____

Initials: _____