



Meal Plan Waiver Request Form

Valid For One Term Only

Student ID#

Full Name:

Email:

*You will be notified via email when a decision has been made.

Please choose one of the following:

Dietary Restrictions

() **Medical:** A detailed diet prescribed by a physician must be faxed or emailed directly to the College. An Aramark dietician will review the diet. If the dietician is unable to accommodate the prescribed diet, a full or partial waiver will be granted.

Religious: A detailed description of dietary restriction from a recognized religious leader must be faxed or emailed directly to the College. An Aramark dietician will review the diet. If the dietician is unable to accommodate the prescribed diet, a full or partial waiver will be granted.

Financial Hardship/Other Exigent Circumstances

Significant financial or exigent experience such as job loss, medical expenses, natural disasters, death or other income reducing experiences. Documentation is required specific to the hardship or circumstance, such as FAFSA, SNAP, unemployment benefits, medical expenses, or other applicable financial documents.

I have read the conditions of the Meal Plan Waiver Form and by signing I agree to the conditions put forth in this waiver request. I realize that I must reapply for a meal plan waiver each term.

Print Name

Date

Instructions: Complete this form and return along with required documentation as outlined below. Please save the documentation as an attachment and send via email to the address below or fax to the number below. **Forms will not be processed without documentation.** Decisions made by the evaluation committee are final and cannot be appealed.

Deadline: Waiver requests must be submitted no later than September 30th for the fall semesters and February 28th for the spring semesters. If your request is approved your bill will be adjusted by the amount of the waiver granted. Any issues arising after the deadline will be addressed on an individual basis.

Return to: Waivers can only be submitted via email to mealwaiver@sunysuffolk.edu or faxed to (631) 451-4444.

For Business Office Use Only

Date Received _____

Approved

Denied

Administrator Signature

Reason for denial