APPLICATION FOR REFUND

CSU Bakersfield
Extended Education and Global Outreach

9001 Stockdale Highway – 30BDC
Bakersfield, California 93313

661.654.2441 | 661.654.2447 (f)
extended.csub.edu

I, _____, request the allowable amount of refund for the fees I paid for:
First and Last Name

Term (choose one): Fall ☐ Winter ☐ Spring ☐ Summer ☐ Year: _____

Student's Signature: _____ Date: _____ CSUB ID#: _____

Reason For Refund:

_____

_____

_____

Please Check One: ☐ Pick Up Check
☐ Mail Check (Refund will be mailed to the address on file with the records office on the date the check is issued.)

FOR OFFICE USE ONLY

Approved By: _____ Date of Withdrawal: _____
Dean of EEGO

FEE TYPE	AMOUNT PAID	REFUND AMOUNT	PMT. DETC.	TNUM	DATE POSTED
Registration					
Tuition					
Totals					

I certify that fees in the amount of $ _____ were collected.

Accounting Office Signature: _____ Date: _____

Check No. _____

Date Issued _____

DETC (if applicable) _____

Account No. (if applicable) _____