



APPLICATION FOR REFUND

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) _____

Nondiscrimination Policy

EEOG does not discriminate on the basis of race, color, national origin, sex, physical handicap, or sexual orientation in the educational programs or activities it conducts. Students admitted with physical, perceptual or learning disabilities will be given necessary accommodations provided that their disability has been verified by the CSUB Office of Services for Students with Disabilities (661-654-3360).