Schuylkill Intermediate Unit 29

Serving the Needs of Education

DIANE M. NIEDERRITER, ED.D.
Executive Director

FULL-TIME STUDENT MEDICAL ELIGIBILITY FORM

Complete All Sections

SECTION 1	**EMPLOYEE INFORMATION**
Employee Name:	**SSN:**
Employer:	
SECTION II	**DEPENDENT INFORMATION**
Dependent Name:	**Dependent Date of Birth:**
Name of Accredited College/University:	
School Address:	
Number of Credit Hours:	**Anticipated Date of Graduation*:**

If full-time student status is no longer applicable, please inform the Business Office and indicate the date student status was terminated.

SECTION III EMPLOYEE CERTIFICATION

I certify that the above information is current and accurate and that the dependent listed above is eligible for benefits provided by my employer for full-time students.

Employee Signature _____ **Date** _____

**** A copy of the student's course schedule must be submitted as proof of eligibility with this form.**

OFFICIAL USE ONLY	
Approved by:	**Date:**

Manual Web Forms DMN 8/2012