

Saint Luke's College of Health Sciences

Third Party Payment Notification

Note: Please complete and return this form indicating any third party payments (VocRehab, VA Benefits, Workforce Initiative, etc.) you will be receiving. This form is **not** for students to reflect scholarships.

Term: _____

Student Name _____
(Please print)

Student ID Number _____

<u>Charge Type</u>	<u>Amount</u>	<u>-or-</u>	<u>In Full</u>
Tuition	\$		<input type="checkbox"/>
Fees	\$		<input type="checkbox"/>
Books	\$		<input type="checkbox"/>

Organization Information

Name of Funding Organization: _____

Funding Organization Contact Person: _____

Contact Phone Number: (____)____-_____

Does SLCHS need to invoice this funding organization? _____ (YES/NO) If yes, please **attach necessary documentation**.

Special Instructions:

Reminders:

- Any portion of tuition and fees not covered by third party is due the first week of classes.
- You are ultimately responsible for all tuition and fees.

Student Signature _____ Date _____

**Return completed form to: Saint Luke's College of Health Sciences
Business Office
624 Westport Road
Kansas City, MO 64111**