STATE EMPLOYEE
TUITION FEE WAIVER FORM

OFFICE OF THE REGISTRAR
11000 University Parkway, **Bldg 18** Pensacola, FL 32514
Telephone: 850.474.2244 Fax: 850.473.7345
registrar@uwf.edu

For **State Employees** attending UWF; employees of the Executive, Legislative, and Judicial branches of state government.

UWF ID Number:________________________ Name:____
First Middle Initial Last

Street Address:______________________________________City:____________________State:_______Zip Code: ____________

Agency Name:_________________________Job Title:______________________Email Address*:_____________________
*Valid Email Required

Indicate your category (mark only one): ☐ State Employee ☐ Executive Branch ☐ Legislative Branch ☐ Judicial Branch

Student Status (mark only one): ☐ Current Student ☐ New/ Readmitted Student (Required)

REGISTRATION INFORMATION

REGISTRATION TERM: Year_____Semester: ☐ Fall ☐ Spring ☐ Summer **Total number of credits hours:** ______

List course(s) for which you desire approval:

5-digit CRN (REQUIRED)	Subject Course Number	Course Title	Credit Hours

List alternative course(s) below:

5-digit CRN (REQUIRED)	Subject Course Number	Course Title	Credit Hours

I acknowledge and understand the following limitations:

☐ I must be admitted to the University as a full-time State employee

☐ I may request up to 6 credit hours per semester.

☐ I must turn in my **State Employee Tuition Waiver Form** after course registration (during the add/drop period).

☐ I may only register for course(s) during the designated State Waiver registration period. If I register prior to that period, I will assume financial responsibility for the course(s). State Waiver registration dates may be found at https://uwf.edu/offices/registrar/tuition--fees/state-employee-tuition-waiver/

☐ I understand certain fees are not covered, therefore, an account balance may be due.

☐ I have read and acknowledge the State Employee tuition fee waiver policy found at https://uwf.edu/offices/registrar/tuition--fees/state-employee-tuition-waiver/

Employee Signature: ______________________ Date: __________

***I certify this employee is employed by the State of Florida in a full-time salaried position (excluding OPS), and has the approval of the agency head or designee to participate in this program.**

Supervisor of Agency Head* (or Equivalent) ______________________ Date: __________
Signature Printed Name

Position Title:_____________________________Phone Number:________________Email Address: ________________

In accordance with FS 1009.265

OFFICE USE ONLY:
DATE RECEIVED:_____________DATE PROCESSED:_____________PROCESSED BY:_______________FORWARD CASHIER: ______________