

**APPEAL OF
THE UNIVERSITY OF TOLEDO MEAL PLAN POLICY**

Complete all the information listed below and sign where indicated, if applicable. return completed form to Card & Parking Services, The University of Toledo, 1610 Rocket Hall MS 316, Toledo, Ohio 43606. (419) 530-5842.

STUDENT INFORMATION

Applicant Name _____
Student ID# _____ - _____ - _____ Date of Request _____
Permanent Address _____
City/State/Zip _____
Local Address _____
Permanent Phone # _____ Local Phone # _____

What specific problem(s) or circumstances are you experiencing or do you plan to experience with your Meal Plan?

Have you met with AVI regarding these problems? **Yes** **No**

If yes, what was their resolution? _____

What Meal Plan do you have? **Block 125** **Any 10** **Cont. M-F** **Cont. M-S**

Which Meal Plan to would you prefer to have? _____

Is your appeal based on your personal health issues? **Yes** **No**

If yes, complete the box below and forward the Physician's Statement form to your medical physician for completion. **The statement must be completed by a licensed Physician.** Please return both sections to Card & Parking Services.

AUTHORIZATION TO RELEASE OF MEDICAL INFORMATION

I authorize the release of this information to my physician and authorize my physician to release to The University of Toledo Card & Parking Services department the medical information requested to the University of Toledo, Card & Parking Services department, in support of my request for a Meal Plan change. I understand that my physician may require me to sign an additional form for release of this information to the University.	
Signature _____	Date _____

PHYSICIAN'S STATEMENT

The applicant has stated that due to their specific medical condition, they need to change or not participate in a University Meal Plan. To assist us the University in reaching a decision on their request, we require the following information about the applicant's medical condition. Please complete the information below.

PHYSICIAN INFORMATION

Name _____	Phone _____
Specialty _____	Medical License # _____
Address _____	
City/State/Zip _____	

REPORT OF APPLICANT'S MEDICAL CONDITION

Please explain the applicant's medical condition.

How will changing or not participating in the University Meal Plan benefit the applicant's medical condition?

Does the applicant require regular treatment? **Yes** **No**

If yes, how often? _____

Is the medical condition temporary? **Yes** **No**

If temporary, what is the duration of the condition?

From _____ **through** _____ (Please be as specific as possible)

Please share any additional information you have which may assist us in this appeal.

Signature _____ Date _____