

**TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER EL PASO
SPECIAL INSTRUCTION FEE REQUEST**

To: Chief Financial Officer, or designee.

Date: _____

Name of Department: _____

Course/Section Number(s):

| | | | |
|--|--|--|--|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Amount to be collected from each student: \$ _____

Indicate by checking (✓) the appropriate block if this charge (amount) is per credit hour or a flat rate charge.

This is per credit hour.

This is a flat rate charge.

Please PRINT or TYPE the fee description to be printed on the student's billing (30 character limit).

Effective Semester(s): _____

Please check (✓) the appropriate block below:

This is for the above indicated semester(s) only.

This is to continue until rescinded, beginning with the above semester, for all semesters or summer terms.

This is to continue until rescinded, beginning with the above semester for _____ sessions only. Please check (✓) the appropriate block for the semester(s) or term(s):

Fall Spring 1st Summer 2nd Summer

Provide a short narrative stating the purpose of the special fee or nature of special activity (attach additional page(s) as necessary.)

