SUNY DOWNSTATE MEDICAL CENTER

Office of Student Financial Aid
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2018-2019 Federal Work Study Increase Request Form

Section A

Student Name: ___________________________ *ID#:* __________________________________

Original Awarded Amount	Requested Amount

Reason:____

____

____

____

Student Signature: _______________________

Section B: This section must be completed by your supervisor

Supervisors Name: __________________________________
Supervisors Email Address: __________________________
Supervisors Telephone Number: _______________________

On average, how many working hours a week does the above student complete? ___
Please give brief job description.

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Supervisor Signature: __________________

Office use only:

Prior requests? _____
Comments:

*Approved*______ *Denied:* ______ *Officer's Initials:* ________