Graduate and Continuing Studies

The Cooper Health System

Tuition Discount Verification Form

Year: _____ Term (Select one) ☐ Fall ☐ Spring ☐ Summer

Section A. **(*Completed by student)***

I hereby authorize certification of my employment/membership status to Widener University.

Print Name: _____

Student ID: _____ **Program:** ☐ Undergraduate ☐ Graduate

Signature: _____ **Date:** _____

_____

Section B. ***(Completed by (The Cooper Health System***

☐ I certify that the above-named student is an employee of The Cooper Health System and eligible for tuition discounts as outlined in the official Memorandum of Understanding between Widener University and The Cooper Health System.

Signature: _____ **Date:** _____

Print Name: _____

Title:_____

Submit form for each semester enrolled via email to:

Widener University

Graduate and Continuing Studies

Gel@Widener.edu