1400 S. Wolf Rd., bldg.400, Wheeling, IL 60090
Ph: 847-243-7113
info@solexian.com

Request for REFUND

Student Name:			
	Last Name/Family Name *First Name/Given Name* *Middle Name*		
ID Number:		Date of Birth:	_____/ _____/ _____

ADDRESS:

Number, Street, Apt. _____

City, State, Zip Code _____

PHONE NUMBER: _____

E-MAIL: _____

Allow 10 business days for processing

Please check one: ☐ Send by mail ☐ Student Pick Up **(Picture ID Required)**

Requested refund amount: $ _____

SEND THE CHECK BY MAIL TO:

Make the check payable to: _____

Address: _____

Number, Street, Apt.

_____

City, State, Zip Code

STUDENT SIGNATURE: _____ ***DATE:*** _____

DO NOT WRITE BELOW. FOR OFFICE USE ONLY.

Refund check prepared by: _____ Date: _____

Refund request received by: _____ Date: _____

Refunded amount: $_____

☐ Sent on: _____ ☐ Picked Up on: _____