



# REQUEST FOR ADDITIONAL WORK STUDY

**BORROWER SECTION** **PLEASE PRINT ALL INFORMATION**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

University ID Number (UIN): **A00** \_\_\_\_\_

Please select the additional amount of work study you are requesting:  \$1,000  \$2,000

*Note: Increases to a Federal Work Study (FWS) award are based on available funding, a student's remaining need and the FWS supervisor's approval. You must reference your **Cost of Attendance** and **Award Package** located online at <https://my.umdj.edu> to determine your remaining eligibility.*

**School:**

**Campus:**

\_\_\_\_\_ Graduate School of Biomedical Science

\_\_\_\_\_ Camden

\_\_\_\_\_ New Jersey Medical School

\_\_\_\_\_ Newark

\_\_\_\_\_ Robert Wood Johnson Medical School

\_\_\_\_\_ Piscataway

\_\_\_\_\_ School of Nursing

\_\_\_\_\_ Scotch Plains

\_\_\_\_\_ School of Osteopathic Medicine

\_\_\_\_\_ Stratford

\_\_\_\_\_ School of Public Health

\_\_\_\_\_ Web Based

\_\_\_\_\_ School of Health Related Professions – Program: \_\_\_\_\_

\_\_\_\_\_ New Jersey Dental School

\_\_\_\_\_ New Jersey Dental School Post Graduate – Program: \_\_\_\_\_

**Grade Level** 1 2 3 4 Other (circle one)

\_\_\_\_\_ FWS Recipient's Signature

\_\_\_\_\_ Date

\_\_\_\_\_ FWS Supervisor's Signature

\_\_\_\_\_ Date

**DO NOT WRITE BELOW THIS LINE**

**SCHOOL SECTION**

Action Taken:  Approved  Denied: \_\_\_\_\_

Approval Amount: \$ \_\_\_\_\_ Fund Code: \_\_\_\_\_

Program:  FWS  Community Service

Initial / Date: \_\_\_\_\_