Texas Tech University Health Sciences Center
Student Fees

School/Division:	Contact Person:
Fund (if new, leave blank):	Name of Fee:
Please check: ___ New Fee ___ Rate Adjustment (Select: ____ Increase or ____ Decrease) ___ Update Only (Purpose of Student Fee) Complete Section 4 only	
Current Fee Rate (if new, enter $0)	Date of Last Rate Adjustment (if new, leave blank):
Proposed Fee Rate:	Charge Basis (per SCH/semester/annual):
Proposed Effective Date of New/Adjusted Fee:	
Statutory Authority for Collecting Fee:	

1. List all Programs to be assessed the fee:

_____

_____

2. Revenue Estimate (Annual):

_____ Number of Students x $_____ (fee rate per year) = $_____

3. Expense Estimate (Annual):

_____ $_____

_____ $_____

_____ $_____

_____ $_____

Total Expenses $_____

4. Per statute, student fees may only be used for the purpose in which they are assessed. Please provide a description of the purpose of this fee and the specific types of expenses directly related to this fee.

5. Rationale for requesting a rate adjustment to an existing fee or charge or for requesting a new fee. Indicate why other sources of revenue are not appropriate to support this fee and outline the use of the fee:

6. In pricing the requested fee, please list and attach any supporting evidence of market analysis and comparison of the fee to other peer or comparable regional institutions. If the proposed fee is not easy to compare to other institutions, please provide compelling evidence as to why the proposed fee differs significantly.