



DOWNSTATE
HEALTH SCIENCES UNIVERSITY

Office of Student Financial Aid
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2024-2025 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.

Supervisor Signature: _____

Prior requests? ____

Comments:

Office use only:

Approved _____ Denied: _____ Officer's Initials: _____