Welcome Center
Phone: (617) 322-3517
Fax: (617) 296-7947

Federal Financial Authorization Form – Parent Loan Borrower

Name of Parent PLUS Loan Borrower _____

Student Name_____ Student ID# _____

E-mail_____ Telephone number _____

I understand that this authorization is voluntary and will remain valid. Labouré will continue to withhold the credit balance for future semester(s) unless a written request to cancel is received by Student Accounts.

☐ **YES**. I voluntarily authorize Labouré College of Healthcare to retain and manage my FSA credit balance as described above, and I acknowledge that the interest will not be earned on these balances. I understand the authorization may be withdrawn at any time by providing a written request to Student Accounts.

☐ **NO**. I do not authorize Labouré College of Healthcare to hold my credit balance and understand that any credits will be refunded to me within 14 days of the disbursement.

☐ **NO**. I do not authorize Labouré College of Healthcare to hold my credit balance and understand that any credits will be refunded to my child, within 14 days of the disbursement.

PLUS Loan Borrower Signature _____ Date _____

Please sign and return this form to Student Accounts:

Labouré College of Healthcare
Student Accounts
303 Adams Street
Milton MA 02186

Revised 05/24/2021