

This form is to be completed in its entirety by the Department Chair of your health professions program.

Please attach the following to this completed form:

- Documentation of the courses and credits you are taking for the semester appealed (i.e. class schedule); and
- A copy of the program curriculum from the institution's catalog or website.

SECTION A: Student Information

STUDENT FULL NAME: _____

STUDENT'S SSN OR MHEC ID: _____

INSTITUTION NAME: _____

PROGRAM OF STUDY: _____

SECTION B: Course Description

SEMESTER: _____ CREDIT HOURS: _____

COURSE TITLE: _____

(i.e.: NURS 201, Fundamentals of Nursing)

COURSE COMPOSITION:

CLINICAL HOURS per week _____ per semester _____

LAB HOURS per week _____ per semester _____

LECTURE HOURS per week _____ per semester _____

Other: _____ per week _____ per semester _____

TOTAL HOURS per week _____ per semester _____

SEMESTER: _____ CREDIT HOURS: _____

COURSE TITLE: _____

(i.e.: NURS 201, Fundamentals of Nursing)

COURSE COMPOSITION:

CLINICAL HOURS per week _____ per semester _____

LAB HOURS per week _____ per semester _____

LECTURE HOURS per week _____ per semester _____

Other: _____ per week _____ per semester _____

TOTAL HOURS per week _____ per semester _____

SEMESTER: _____ CREDIT HOURS: _____

COURSE TITLE: _____

(i.e.: NURS 201, Fundamentals of Nursing)

COURSE COMPOSITION:

CLINICAL HOURS per week _____ per semester _____

LAB HOURS per week _____ per semester _____

LECTURE HOURS per week _____ per semester _____

Other: _____ per week _____ per semester _____

TOTAL HOURS per week _____ per semester _____

SEMESTER: _____ CREDIT HOURS: _____

COURSE TITLE: _____

(i.e.: NURS 201, Fundamentals of Nursing)

COURSE COMPOSITION:

CLINICAL HOURS per week _____ per semester _____

LAB HOURS per week _____ per semester _____

LECTURE HOURS per week _____ per semester _____

Other: _____ per week _____ per semester _____

TOTAL HOURS per week _____ per semester _____

NOTES: _____

SECTION C: DEPARTMENT CERTIFICATION

Is the program considered full-time because of clinical requirements? (Circle one: YES or NO) If NO, the student is not eligible for the appeal and should be considered for the Part-Time Grant.

FORM COMPLETED BY: _____

Print Full Name

SIGNATURE: _____

TITLE: _____ DEPARTMENT: _____

INSTITUTION NAME: _____

PHONE NUMBER: _____

E-MAIL ADDRESS: _____

DATE: _____/_____/_____

IMPORTANT: All appeal requests must be submitted online. Students are required to upload this form, and all required documents, at the time their appeal is submitted.

The Department Chair *must* return the completed certification form to the student.

The form must be completed by the following deadlines:

Fall Deadline: October 15, 2021

Spring Deadline: March 15, 2022