OFFICE OF FINANCIAL AID

REQUEST FOR SAP REINSTATEMENT

NSHE ID | LAST NAME | FIRST NAME | MI

Please allow 30 days for the Financial Aid Office to review your request from reinstatement. If you are currently enrolled, ***please make payment arrangements with the Cashier's Office in order to secure your enrollment.*** **Complete Section 1 or Section 2, NOT both.** Section 1 requires a completed Academic Rehabilitation Plan signed by you and your counselor/health science advisor.

STEP 1: INDICATE THE SUSPENSION CONDITION YOU ARE REQUESTING REINSTATEMENT:

Attach an Academic Rehabilitation Plan to this request *if* requesting to be reinstated due to *Maximum Time Frame*

☐ Qualitative – Less than a 2.0 cumulative GPA at CSN.

☐ Quantitative – Did not meet or maintain the 67% PACE of completion requirement (*completed credits divided by attempted credits*).

☐ I have reached my Maximum Time Frame because of the following reason(s):

☐ Military Training ☐ Apprenticeship Instruction/Training ☐ Certificate Training

☐ I have a prior degree from CSN or another institution (please indicate type of degree and school (i.e., AGS, College of Southern Nevada) _____

Please attach a transcript to this Request for SAP Reinstatement

☐ I was directly or indirectly affected by the COVID-19 pandemic and could not successfully complete my class(es) - Please provide a typewritten and signed statement explaining how you were affected.

☐ Other:

STEP 2: INDICATE HOW THE SUSPENSION CONDITION WAS MET:

☐ My cumulative GPA at CSN is now at 2.0 or higher.

☐ I have successfully completed coursework at CSN or another institution and am now at a 67% completion rate or higher and I have had those transcripts evaluated by the Registrar's Office.

☐ I did not receive a warning semester.

☐ Other:

STEP 3: SIGNATURE:

_____ _____

Student Signature - Your typed name will serve as your signature | Date

SCHOOL USE ONLY – DO NOT WRITE BELOW	
☐ APPROVED ☐ DENIED	
COMMENTS:	
FAA SIGNATURE:	DATE:

ACADEMIC REHABILITATION PLAN

(To be Completed by a CSN Counselor or Health Science Advisor)

Student Name:_____ Catalog Year:_____

NSHE #:_____ Declared Major:_____

Section 1: Only includes classes that lead towards the completion of the declared major. Add course name and number. The student must be enrolled in the classes, as listed on this form.

FIRST SEMESTER RECOMMENDED CLASSES	**SECOND SEMESTER RECOMMENDED** CLASSES	**THIRD SEMESTER RECOMMENDED** CLASSES
Term - _____	**Term - _____**	**Term - _____**
Course:_____ Crd:_____	Course:_____ Crd:_____	Course:_____ Crd:_____
Course:_____ Crd:_____	Course:_____ Crd:_____	Course:_____ Crd:_____
Course:_____ Crd:_____	Course:_____ Crd:_____	Course:_____ Crd:_____
Course:_____ Crd:_____	Course:_____ Crd:_____	Course:_____ Crd:_____
Course:_____ Crd:_____	Course:_____ Crd:_____	Course:_____ Crd:_____

Total Credits Remaining Until CSN Graduation:	Total Transfer Credits Brought to CSN by Student:	Total Transfer Credits That Apply to CSN Degree, Including Previous CSN Degree Credits:

ADDITIONAL RECOMMENDATIONS

☐ I agree to visit/revisit with my counselor/health science advisor to review my progress prior to enrolling in the second semester of this plan.
☐ I agree to take the ☐ Math and/or ☐ English *(check one)* Placement Exam at the CSN Testing Center before the next enrollment period.
☐ I agree to visit the Math & Science Drop-in Labs a minimum of_____ times during the first semester of this Plan and, if asked, will submit proof of my visit(s).
☐ I will utilize CSN Tutorial Services for the following class (es):_____
☐ I will seek accommodations from the CSN Disability Resources Center during the course of this Plan.
☐ Other: _____
☐ Other: _____

Counselor/Health Science Advisor Print Name:_____

Effective Date: _____**Department**:_____**Email**:_____

I acknowledge and understand that *any failures or withdrawals (including audits) will invalidate this plan* and place me back on Financial Aid SAP suspension. I agree to follow this Academic Rehabilitation Plan and if any changes are required, I agree to meet with my counselor/health science advisor to create and submit an updated Academic Rehabilitation Plan to the Financial Aid Office.

Agreed and Acknowledged by: _____ Date:_____

(Student Signature – Your typed name will serve as your signature)