

Student instructions to complete SAP or reinstatement appeals **during the campus closure:**

For HEALTH SCIENCE majors:

All health science majors requesting a SAP appeal or reinstatement whether pursuing a program or in a limited entry program must **first** complete an [Online Health Programs Orientation](#) if you haven't previously attended one and schedule a **remote** appointment with a health programs advisor for a one-hour appointment through <https://hpa.mywconline.com/>

For All Other majors: (e.g., Non-Health Science majors)

All other (e.g., non-health science) majors requesting a SAP appeal or reinstatement should schedule a remote appointment (e.g., phone, email, and web conference) with a counselor through MyCoyotePLAN. You will find instructions for scheduling an appointment at <https://www.csn.edu/counselingdepartment>



OFFICE OF FINANCIAL AID

2021-2022 SATISFACTORY ACADEMIC PROGRESS APPEAL



Submit your completed SAP Appeal to sap@csn.edu using your official CSN student email address

Section 1: STUDENT INFORMATION

NSHE Last NAME First Name MI

I am requesting this appeal for the following semester(s): [] Fall 2021 [] Spring 2022 [] Summer 2022

I understand that I am required to "sit-out" a semester from financial aid - I can enroll into classes, but will have to pay for those classes out of pocket.

Section 2: CHECK THE REASON YOU ARE REQUESTING THIS APPEAL:

- [] My CSN cumulative Grade Point Average (GPA) is below the required 2.0 GPA
[] I am NOT on PACE to graduate (earned credits divided by attempted credits are less than the 67% minimum)
[] My total attempted credits at CSN and/or my transfer credits exceeds 150% of the total credits needed to graduate
[] I already have a college degree or certificate and want to pursue an additional degree/certification - complete below:

Degree Awarded: _____ Awarding Institution: _____
(Type of degree: CT/AA/BA/etc. and subject - ex: AA-History) (Name of College/University)

**Note: If you transferred to CSN, it is recommended to have your official transcripts from all previously attended institutions evaluated by the Office of the Registrar before submitting this appeal.

Section 3: REQUIREMENTS - NOTE: Incomplete appeal forms will be denied.

Please Read and Initial all of the following requirements.

_____ A Signed, Typewritten Personal Statement explaining:

- 1. Any extenuating circumstances that caused you to be placed on SAP suspension;
2. How the extenuating circumstance(s) caused your academic under-performance; and
3. What you have done to overcome the extenuating circumstance(s).

_____ Official documentation that supports your extenuating circumstance(s) (copies);

_____ A completed CSN Academic Rehabilitation Plan signed by you and your Counselor/Health Science Advisor;

_____ Enrollment for the appropriate semester. Your enrollment MUST match your Academic Rehabilitation Plan;

_____ Completion of Financial Awareness Counseling (www.studentaid.gov) and complete the Financial Awareness Counseling Tool). Attach a copy of the completed Financial Awareness Counseling Tool to your SAP appeal;

_____ Completion of all five (5) of FATV's GETSAP Video Module (csn.get-counseling.com) with a score of 90% or greater
Attach proof of completion of all five (5) of the FATV GetSAP video modules;

_____ Payment Arrangement - I understand the Office of Financial Aid will NOT hold my classes pending a decision by the SAP committee. I further understand that it is my responsibility to pay for my courses in order to remain enrolled if a decision is still pending; and

_____ I understand that the decision of the SAP Committee is Final. All decisions will be rendered 30 days following the SAP appeal deadline date.

Section 4: CERTIFICATION AND STATEMENT OF UNDERSTANDING:

I, _____, certify that the information contained within this appeal, including all attachments and enclosures, is accurate and truthful. I understand this information may be shared with members of the CSN Satisfactory Academic Progress (SAP) committee and, as part of my permanent financial aid record, may be reviewed by federal employees, their agents, or others contracted by CSN to evaluate the administration of Title IV financial aid programs. I agree to follow the conditions of this appeal and the Academic Rehabilitation Plan. I understand that I must meet with my counselor/health science advisor to revise my Academic Rehabilitation Plan if anything changes.

Student Signature (Your typed name will act as your physical signature) _____ Date _____



ACADEMIC REHABILITATION PLAN

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

Submit your completed SAP appeal to sap@csn.edu using your official CSN student email



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: <input type="text"/>	Total Transfer Credits Brought to CSN by Student: <input type="text"/>	Total Transfer Credits That Apply to CSN Degree, Including Previous CSN Degree Credits: <input type="text"/>
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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 _____ 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 act as your physical signature)