

DEADLINE

Six weeks before your study period end date.

WHAT IS AN APPEAL?

An appeal is the process by which you have the opportunity to request a reconsideration of your assessed award. If you have had an exceptional circumstance that meets one or more of the criteria listed below and you have not received the maximum amount of funding for the application study period, you may submit an appeal request. Once evaluated, the appeal request may result in a change to your StudentAid BC award.

APPEAL CRITERIA

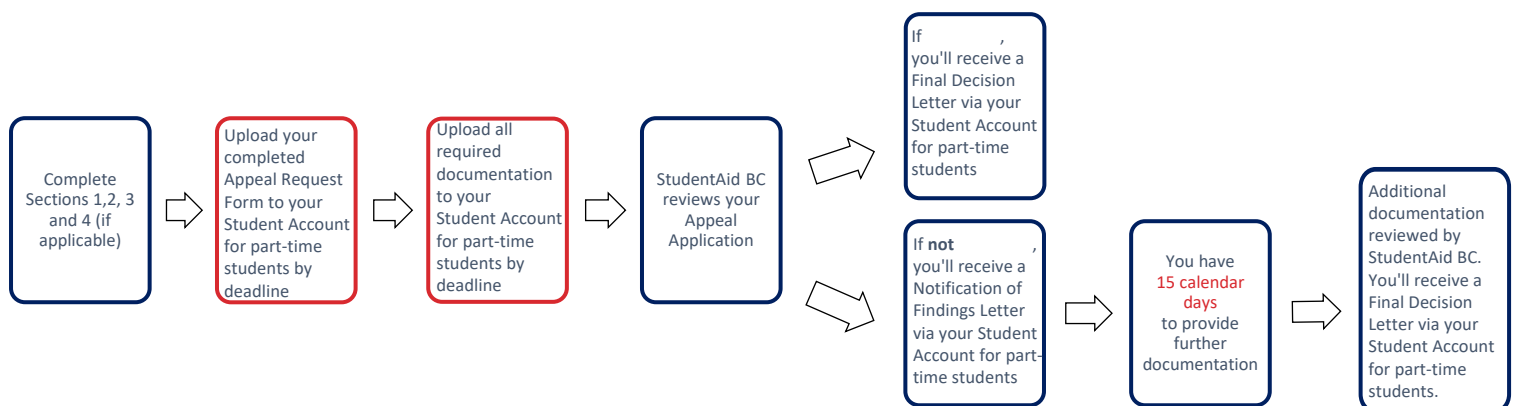
If you are a part-time student who withdrew or failed to successfully complete your studies while receiving StudentAid BC funding, you will have a restriction placed on your file and will not be eligible for further funding until you have successfully completed one self-funded semester at a designated post-secondary institution.

You can complete one self-funded semester at a designated post-secondary institution or you can appeal your scholastic standing *if* you were otherwise on track to successfully complete your program and one or more of the following criteria has impacted your ability to study:

- Medical illness or injury
- Family emergency (e.g., death or injury)
- Natural disaster
- Other exceptional circumstance

APPEAL INSTRUCTIONS

1. Talk to a Financial Aid Officer at your school, they can help you with the appeal process. If you are unable to contact a Financial Aid Officer, contact [StudentAid BC](#).
2. Review the Appeal Criteria.
3. Complete Sections 1, 2 and 3.
4. If your appeal circumstance is due to a medical reason, review Section 4 – Medical Withdrawal Instructions.
5. Upload your completed Appeal Request Form and all required documentation to your [Student Account for part-time students](#).



Appeal Request Form starts on page 2.



STUDENT'S SOCIAL INSURANCE NUMBER

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[illegible][illegible][illegible]

MIDDLE INITIAL

You must upload all of the following documentation via your [Student Account for part-time students](#) to support your appeal request:

A letter explaining the circumstance(s) that meets one or more of the Appeal Criteria (see page 1).

A letter from your institution confirming your ability to complete the program.

A completed Section 4 with your doctor/counsellor's signature and stamp (if your appeal circumstance is due to a medical reason).

YOUR ASSESSMENT WILL BE DELAYED OR DENIED IF YOU DO NOT SUBMIT ALL REQUIRED DOCUMENTATION.

By submitting this request for an appeal, I understand that:

- All terms agreed to on my application will remain in force.
- StudentAid BC may consider information from prior applications in my appeal request.

If Section 4 (Medical Withdrawal) is completed by doctor/counsellor:

- I consent to the release of information from my doctor or counsellor to the Ministry of Post-Secondary Education and Future Skills, StudentAid BC.
- I understand that this information will be used to determine whether StudentAid BC approves my appeal due to my medical condition.

X	CHECK MARK	PRINT STUDENT'S FIRST AND LAST NAME	MM/DD/YYYY

Collection and use of information: The information included in this form and authorized above is collected under Sections 26(c) and 26(e) of the *Freedom of Information and Protection of Privacy Act*, and under the authority of the *Canada Student Financial Assistance Act*, R.S.C. 1994, Chapter C-28 and StudentAid BC. The information provided will be used to determine eligibility for a benefit through StudentAid BC and for statistical and evaluation purposes. If you have any questions about the collection and use of this information, contact the Director, StudentAid BC, Ministry of Post-Secondary Education and Future Skills, PO Box 9173, Stn Prov Govt, Victoria B.C., V8W 9H7, telephone 1-800-561-1818 (toll-free in Canada/U.S.) or +1-778-309-4621 from outside North America.

Upload completed Appeal Request Form and all required documentation to your [Student Account for part-time students.](#)



INSTRUCTIONS TO THE DOCTOR/COUNSELLOR

This form will not be processed without a doctor's/counsellor's stamp.

PATIENT'S LAST NAME

[illegible]

PATIENTS'S FIRST NAME

[illegible]

NAME OF DOCTOR/COUNSELLOR

[illegible]

MAILING ADDRESS

[illegible]

CITY/TOWN

[illegible]

PROVINCE/STATE

COUNTRY

--

POSTAL/ZIP CODE

--	--	--	--	--	--	--	--

AREA CODE

--	--	--

PHONE NUMBER

--	--	--	--	--	--	--

DOCTOR/COUNSELLOR STAMP

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- | | | | |
|----|---|--|-----------|
| 1. | When was this medical condition first diagnosed? _____ | | |
| 2. | Given the patient's medical condition, would they have been able to maintain their initial course load for part-time studies (between 20% to 59% of a full-time course load) and complete the rest of the study period? | YES | NO |
| | If NO , briefly explain why: _____ | | |
| 3. | Did you advise the patient to withdraw from part-time studies due to their medical condition? | YES | NO |
| | If YES , what was the date? _____
<div style="text-align: center; color: #ccc;">MM/DD/YYYY</div> | If NO , indicate the date of illness: _____
<div style="text-align: center; color: #ccc;">MM/DD/YYYY</div> | |
| 4. | Briefly describe the nature of the student's illness: _____ | | |
| 5. | Is this student fit to return to school? | YES | NO |

X

SIGNATURE OF DOCTOR/COUNSELLOR

PRINT DOCTOR/COUNSELLOR'S NAME

MM/DD/YYYY

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