

Appeal Request Form Instructions

SCHOLASTIC STANDING FOR FULL-TIME STUDENTS

MULTIPLE WITHDRAWALS FROM STUDY, UNSUCCESSFUL STUDIES, OR OVERAWARD

The requirement to maintain eligibility during your study period is found in Chapter 9 (Maintaining Eligibility) and the requirement to notify any changes in your circumstances is found in Chapter 10 (Changes to Student Circumstances) of the 2018/19 StudentAid BC Policy Manual , located here: https://studentaidbc.ca/sites/all/files/school-officials/policy_manual.pdf.

APPEAL CRITERIA

Scholastic standing can be appealed when a student is otherwise on track to successfully complete their program and one of the following criteria has impacted their ability to study:

- medical illness or injury;
- family emergency (e.g. death, injury, etc.) or natural disaster; or
- other extraordinary circumstances.

REQUIRED DOCUMENTATION

You must provide the following to support your appeal request:

- a letter from you explaining:
 - why you withdrew on each of the two separate occasions, were unable to successfully complete 68 weeks of study, or any combination of the two;
 - which appeal criteria, noted above, should be considered to set aside the standard requirement that you must complete two semesters or one academic year without funding; and/or
 - which appeal criteria, noted above, should be considered to set aside the overaward (loans only).
- unofficial copy of transcripts showing successful completion of at least 60% of a full-time course load (40% for student with permanent disabilities as approved by StudentAid BC) of post-secondary study for two semesters or one academic year without StudentAid BC assistance, after your last withdrawal or unsuccessful completion that caused your denial of funding;
- letter from institution confirming your ability to complete the program; and
- if appeal circumstance is due to medical reason - documentation from a qualified medical practitioner stating the date you were advised to withdraw and that you are now in good health and able to maintain at least 60% of a full-time course load (40% for student with permanent disabilities as approved by StudentAid BC).

StudentAid BC cannot guarantee a final decision before your study period ends if all required documentation is not submitted by the appropriate deadline

INSTRUCTIONS TO STUDENT FOR SECTION 3 (MEDICAL WITHDRAWAL), IF REQUIRED

1. If you are asking that your StudentAid BC overawards be set aside due to a medical withdrawal, Section 3 of this form is to be completed by your doctor/counsellor.
2. Complete Sections 1 and 2 and forward this form to your doctor/counsellor to complete Section 3. Your doctor/counsellor will return the form to you.
3. Any fees charged by your doctor/counsellor to complete this form are your responsibility and will not be reimbursed by StudentAid BC.

DEADLINES

**MULTIPLE WITHDRAWAL/UNSUCCESSFUL STUDIES - SIX WEEKS BEFORE STUDY PERIOD ENDS
OVERAWARD - 90 DAYS FROM THE DATE OF THE LETTER ADVISING OF OVERAWARD**

For detailed instructions and potential outcomes from the appeal visit the [StudentAid BC website](#)

Submit completed form to your StudentAid BC online dashboard

Appeal Request Form

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SECTION 1 – STUDENT INFORMATION

ALL QUESTIONS MUST BE ANSWERED IN INK.

(01) SOCIAL INSURANCE NUMBER

(02) STUDENT'S LAST NAME

(03) STUDENT'S FIRST NAME

MIDDLE INITIAL

MINISTRY DATE STAMP

(04) APPLICATION NUMBER

SECTION 2 – DECLARATION

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

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

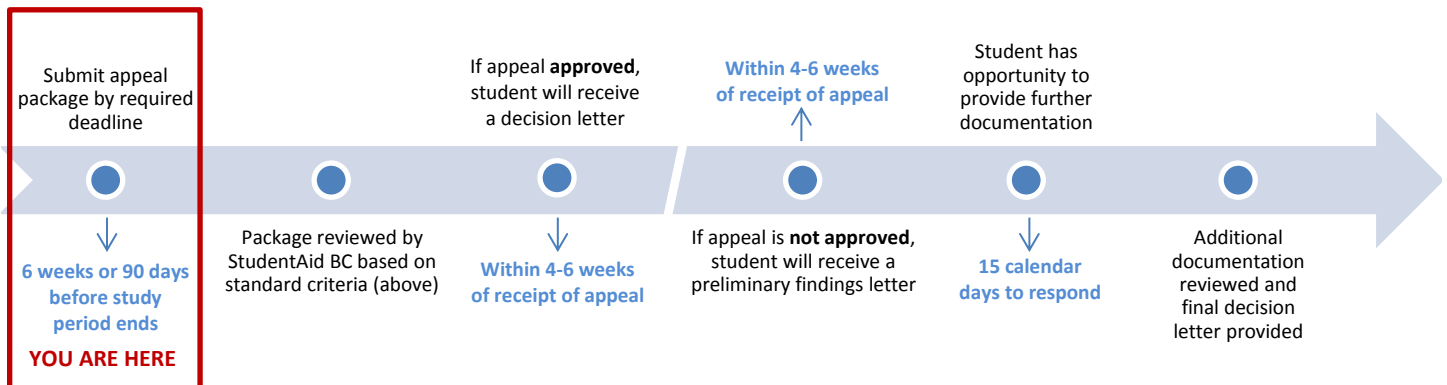
If Section 3 (Medical Withdrawal) is completed by doctor/counsellor:

- 3) I consent to the release of information from my doctor or counsellor to the Ministry of Advanced Education, StudentAid BC.
- 4) I understand that this information will be used to determine whether StudentAid BC approves my appeal due to my medical condition.

X

SIGNATURE OF STUDENT (IN INK)	PRINT NAME	DATE SIGNED
SIGN HERE	PRINT HERE	YYYY / MM / DD

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 Advanced Education, Skills & Training, PO Box 9173, Stn Prov Govt, Victoria B.C., V8W 9H7, telephone 1-800-561-1818 (toll-free in Canada/U.S.) or (250)-387-6100 from outside North America.



SECTION 3 – MEDICAL WITHDRAWAL (TO BE COMPLETED BY THE DOCTOR/COUNSELLOR)

INSTRUCTIONS TO THE DOCTOR/COUNSELLOR

1. Complete Section 3 and return it to the patient.
2. This form will not be processed without a doctor's/counsellor's stamp.

PATIENT'S LAST NAME

[Grid for Patient's Last Name]

PATIENT'S FIRST NAME

[Grid for Patient's First Name]

STAMP OF DOCTOR/COUNSELLOR

[Large empty box for Doctor/Counsellor Stamp]

NAME OF DOCTOR/COUNSELLOR

[Grid for Name of Doctor/Counsellor]

MAILING ADDRESS

[Grid for Mailing Address]

CITY/TOWN

[Grid for City/Town]

PROVINCE/STATE

COUNTRY

POSTAL/ZIP CODE

[Grid for Province/State, Country, and Postal/Zip Code]

AREA CODE

TELEPHONE NUMBER

[Grid for Area Code and Telephone Number]

1. When was this medical condition first diagnosed? _____
2. Given the patient's medical condition, would he/she have been able to continue full-time studies and complete the rest of the study period? [] YES [] NO
If no, briefly explain why: _____
3. Did you advise the patient to withdraw from full-time studies due to his/her medical condition?
[] YES [] NO
If YES, what was the date? YEAR MONTH DAY
If NO, indicate the date of illness: YEAR MONTH DAY
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 (IN INK)	PRINT NAME	DATE SIGNED
	SIGN HERE	PRINT HERE	YYYY / MM / DD

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