INSTITUTIONAL CORRECTION FORM
This form is to correct an inadvertent error on the part of the institution.

Student Name: ____________________________________________________________

Student ID#: ___________________________  Semester & Year ____________________

Student Telephone #: ___________________________  Email: _______________________

CRN & Course #: __________________________________________________________

Does student have Health Insurance Fee on account for term listed above? Yes ____ No ____ If so, and if removal of above course(s) reduces student’s total credit hours for the term to less than 9, does student wish to keep their Health Insurance? Yes ____ No ____

Note: Student Health Insurance cannot be refunded if claims exist or if term has concluded.

Student Signature: ________________________________________________________

The individual taking responsibility for the correction and his/her Dean, Department Chair, Director, Associate VP, or Vice President must sign this form. Required signatures must be from two different individuals.

Tuition and/or fees should be waived for the above student for the following reasons:

DEPARTMENT RESPONSIBLE FOR CORRECTION – CHECK THE APPROPRIATE ACTION BELOW AND RETURN TO THE OFFICE OF THE BURSAR.

_______ DROP  (Delete specific class(es) from academic record.)

_______ WITHDRAW  (Post W grade notation to academic record.)

____________________________________________________  DATE
SIGNATURE & TITLE OF PERSON RESPONSIBLE FOR CORRECTION

_________________________  EXT.
PRINTED NAME

____________________________________________________  DATE
SIGNATURE & TITLE OF DEPT. CHAIR, DEAN, DIRECTOR, VP, OR ASSOC. VP.

_________________________  EXT.
PRINTED NAME