Maryland Higher Education Commission
Office of Student Financial Assistance
6 N. Liberty Street, Ground Suite
Baltimore, MD 21201
(410) 767-3300; (800) 974-1024
TTY for the Deaf - (800) 735-2258
www.mhec.maryland.gov

ENROLLED FOR LESS THAN 12 CREDITS
EA/GA/Promise Programs
CERTIFICATION FORM

This form is to be completed in its entirety by the Department Chair of your health professions program.

Please attach the following to this completed form:
- Documentation of the courses and credits you are taking for the semester appealed (i.e. class schedule); and
- A copy of the program curriculum from the institution's catalog or website.

SECTION A: Student Information

STUDENT FULL NAME: ____

STUDENT'S SSN OR MHEC ID: ____

INSTITUTION NAME: ____

PROGRAM OF STUDY: ____

SECTION B: Course Description

SEMESTER:_____________ CREDIT HOURS:__________

COURSE TITLE:____

(i.e.: NURS 201, Fundamentals of Nursing)

COURSE COMPOSITION:

CLINICAL HOURS per week____ per semester ____
LAB HOURS per week____ per semester ____
LECTURE HOURS per week____ per semester ____
Other: ___________ per week____ per semester ____
TOTAL HOURS per week____ per semester ____

SEMESTER:_____________ CREDIT HOURS:__________

COURSE TITLE:____

(i.e.: NURS 201, Fundamentals of Nursing)

COURSE COMPOSITION:

CLINICAL HOURS per week____ per semester ____
LAB HOURS per week____ per semester ____
LECTURE HOURS per week____ per semester ____
Other: ___________ per week____ per semester ____
TOTAL HOURS per week____ per semester ____

SEMESTER:_____________ CREDIT HOURS:__________

COURSE TITLE:____

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COURSE COMPOSITION:

CLINICAL HOURS per week____ per semester ____
LAB HOURS per week____ per semester ____
LECTURE HOURS per week____ per semester ____
Other: ___________ per week____ per semester ____
TOTAL HOURS per week____ per semester ____

SEMESTER:_____________ CREDIT HOURS:__________

COURSE TITLE:____

(i.e.: NURS 201, Fundamentals of Nursing)

COURSE COMPOSITION:

CLINICAL HOURS per week____ per semester ____
LAB HOURS per week____ per semester ____
LECTURE HOURS per week____ per semester ____
Other: ___________ per week____ per semester ____
TOTAL HOURS per week____ per semester ____

NOTES: ____

Under provisions of the Americans with Disabilities Act, the material is available in alternate formats. Please call (410) 260-4572, (800) 974-1024, or (800) 735-2258 (TTY /Voice).

SECTION C: DEPARTMENT CERTIFICATION

Is the program considered full-time because of clinical requirements? (Circle one: **YES** or **NO**) If **NO,** the student is not eligible for the appeal and should be considered for the Part-Time Grant.

FORM COMPLETED BY: ____

Print Full Name

SIGNATURE: ____

TITLE: ____ DEPARTMENT: ____________________________

INSTITUTION NAME: ____

PHONE NUMBER: ____

E-MAIL ADDRESS: ____

DATE: ________/_________/_________

IMPORTANT: All appeal requests must be submitted online. Students are required to upload this form, and all required documents, at the time their appeal is submitted.

The Department Chair must return the completed certification form to the student.

The form must be completed by the following deadlines:

Fall Deadline: October 15

Spring Deadline: March 15

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