College of Health Professions
Grade Appeal Review Form

(If additional space is required add additional pages and label appropriately)

Student: ___________________________ PLID: ___________________________

Local Address: ___________________________ Local Phone #: ___________________________

Texas State e-mail address: ___________________________

Department/program: ___________________________ Course #: __________ Semester: ___________

Faculty Member Who Assigned Your Grade: ___________________________

Required information to be completed by student:

You were aware of your right to appeal by:

_____ Syllabus
_____ Department Student Policy Manual
_____ University Handbook
_____ Instructor
_____ Other Instructor
_____ Another student
_____ Other (please specify)

Date grade dispute was initially discussed with course instructor: ________________

Date appeal was initiated: ________________

Materials to be submitted in support of this grade appeal include:

_____ course syllabus _____ graded course materials _____ Texas State/CHP policy supporting appeal

Student’s rationale for grade appeal:

Signature of Student ___________________________ Date ________________

(When completed submit this form to the chair/director to initiate the appeal process)
Response to Grade Appeal by Instructor of Record:

Please respond to the following:
Date grade dispute was initially discussed with course instructor: ____________________________

___This response is based on materials submitted by the student (e.g. syllabus, graded material)
or

___This response is based on additional materials being submitted by the faculty member (e.g. syllabus, graded materials, grade calculation)

_________________________________________  ________________________________
Signature of Instructor of Record                                      Date

(Upon completion submit this form to the Department/Program/School Chair/Director within ten days.)
Decision and Rationale of Chair/Director of Department/Program/School:

Signature of Chair/Director

Date

(Upon completion, provide this form to the Student to determine if continuation of the appeal process will occur)
Student's Response to Chair/Director's Decision:

_____ I accept the Chair/Director's decision

______________________________  _______________________
Student's Signature                   Date
(If accepted, file this form in the student's file)

_____ I do not accept the Chair/Director's decision and request the appeal be forwarded to the Dean's Office for additional review

______________________________  _______________________
Student's Signature                   Date
(If not accepted, submit this form to the Dean to progress the appeal process)

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(Upon completion submit this form to the Department/Program/School Chair/Director within ten days.)
Recommendation and Rationale of Grade Appeals Committee:

Signature of Grade Appeal Committee Chair

(When completed, submit this form to the Dean for final consideration of the appeal)
Decision and Rationale of Dean:

______________________________  __________________________
Signature of Dean               Date