

APPLICATION FOR REINSTATEMENT TO COLLEGE OF DUPAGE

Complete this application and return it to the Counseling and Advising Office, Student Services Center, Room 3200, College of DuPage, Glen Ellyn, IL 60137 or via email to SOAP@cod.edu. Applications and supporting materials must be received in a timely manner, therefore we suggest you submit all items by September 1st for Fall semester and February 1st for the Spring semester in which the student is seeking reinstatement.

Name _____ Student ID# _____

Date of Birth _____ Telephone number _____

Address _____

City _____ State _____ Zip _____

Your email _____

1. What semester & year did you begin College of DuPage? _____
2. What semester/year were you dismissed from College of DuPage? _____
3. Was this your first dismissal from College of DuPage? _____
4. Check the academic goal you were pursuing prior to dismissal.

____ AA ____ AS ____ AGS ____ AES ____ AFA-Arts ____ AFA-Music ____ AAT

____ AAS In what? _____

5. Check the academic goal you now wish to pursue upon your return.

____ AA ____ AS ____ AGS ____ AES ____ AFA-Arts ____ AFA-Music ____ AAT

____ AAS In what? _____

6. You are applying for reinstatement effective ____ Fall ____ Spring ____ Summer, Year _____

7. Since your dismissal from College of DuPage, have you attended any other college?

_____ Yes _____ No

If yes, list all institutions, dates attended and number of credit hours completed. NOTE: You must have official transcript(s) sent directly to the Records Office. Applications will not be processed until transcripts are received, if they exist.

INSTITUTION	DATES ATTENDED	CREDIT HOURS
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. Number of additional credit hours you plan to complete at College of DuPage: _____

9. If eligible, do you plan to pursue the Academic Regulations Committee or the Academic Forgiveness Policy? _____ Yes _____ No

10. Were you employed during your attendance just prior to suspension? ____ Yes ____ No

If yes, where? _____ How many hours per week? _____

Do you plan to be employed if you return? ____ Yes ____ No

How many hours per week? _____

How many credit hours per semester do you intend to undertake? _____

By my signature, I attest to the fact that all information given on this application is complete and correct and any omission or falsification will result in denial of reinstatement or dismissal?

Signature

Date of Filing (Student's)

NOTE: Your appeal will be reviewed by the Standards of Academic Progress Committee and you will be notified by email within 10 working days of the decision reached. If your appeal is approved, you will be required to meet with a counselor to develop a success agreement, documenting your plan to achieve academic success. If you are not approved, you will be eligible to reapply for reinstatement in one semester.

Administrative Action

Date: _____

Reinstatement: _____ Approved _____ Disapproved

For: _____ Fall _____ Spring _____ Summer Semester Year _____

Signature