COLLEGE OF MARIN

OFFICE OF ADMISSIONS & RECORDS

Request for Grade Reconsideration

PLEASE PRINT. ALLOW 10 WORKING DAYS, FROM DATE RECEIVED, FOR REVIEW PROCESS.

NAME _____ (LAST) _____ (FIRST) _____ (MIDDLE)

MARIN ID M _____

MAILING ADDRESS:

_____ (NUMBER) _____ (STREET) _____ (APARTMENT)

_____ (CITY) _____ (STATE) _____ (ZIP CODE)

DAY PHONE _____ (AREA CODE) _____ (TELEPHONE NUMBER)

EMAIL ADDRESS _____

COURSE INFORMATION

COURSE TITLE		COURSE NUMBER	
COURSE RECORD NO.		SEMESTER	☐ Fall 20___ ☐ Spring 20___ ☐ Summer 20___

INSTRUCTOR CONTACT

INSTRUCTOR'S NAME			
CONTACT DATE		MEETING DATE	
RESOLUTION			
INSTRUCTOR'S SIGNATURE		DATE	

DEPARTMENT CHAIRPERSON CONTACT

CHAIRPERSON'S NAME			
CONTACT DATE		MEETING DATE	
RESOLUTION			
CHAIRPERSON'S SIGNATURE		DATE	

ACADEMIC / COUNSELING DEAN CONTACT

DEAN'S NAME			
CONTACT DATE		MEETING DATE	
RESOLUTION			
ACADEMIC/ COUNSELING DEAN'S SIGNATURE		DATE	