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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 _____

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	