Office of Financial Aid

6 Pennyfield Avenue • Throggs Neck, NY • 10465
Tel: 718-409-7200 • Fax: 718-409-7275 • Email: financialaid@sunymaritime.edu

Excelsior Scholarship Program: Eligibility Determination Form

STUDENT NAME _____ **MARITIME ID#** _____

TELEPHONE_____ **EMAIL** _____

SEMESTER FOR REVIEW_____ **ACADEMIC YEAR FOR REVIEW**_____

WHO SHOULD COMPLETE THIS FORM?

If you were recently notified by HESC you did not meet requirements for Excelsior scholarship since first enrolling in college due to one of the reasons below, you may still be determined eligible for an Excelsior Scholarship award:

A. failed to complete at least 30-degree applicable credits per year
B. failed to have enough credits accepted by your transfer college
C. failed to be continuously enrolled or had a break in attendance due to
   i. the death or illness of a family member
   ii. documented medical leave
   iii. active military service
   iv. parental leave, or a disability as defined by the Americans With Disabilities Act of 1990, as amended

Fill in the chart to indicate the type of circumstance you are submitting for consideration. Please provide the required documentation, a brief statement explaining the circumstances resulting in your interruption in studies, which prevented you from meeting the Excelsior Scholarship eligibility requirements, along with this completed form. **The statement must be clear, dated and signed by the student.**

Circumstance (check)	Required Documentation
__ Medical Diagnosis	• See Page 2 to completed by your physician/health care provider • Statement from Physician indicating how/why medical condition impacted college attendance
__ Parental Leave	• Provide birth certificate for newborn
__ Illness or critical condition of Immediate Family Member A family member is defined as parent, sibling, child	• Documentation (on official letterhead) from health care provider of ill family member stating the family member was under the care of the student, must include relationship to patient and dates in which supervision and assistance was required of the student.
__ Active Military Duty	• Department of Defense Orders
__ Bereavement- Death of an immediate family member	• Death certificate or copy of obituary

STUDENT AFFIRMATION

By signing below, I understand that all required information and documentation must be provided when submitting the Eligibility Determination Form initially. The eligibility determination made upon review of this request shall be based on rules governing the Excelsior Scholarship and shall be final. I affirm, under the penalty of perjury, that the information I provided, and any supporting documentation submitted, are true and complete and will be accepted for all purposes as the equivalent of a sworn affidavit.

STUDENT'S SIGNATURE_____ **DATE**_____

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MEDICAL INFORMATION TO BE COMPLETED BY LICENSED PHYSICIAN/HEALTH CARE PROVIDER

To the student: If you have indicated that you have/had a medical diagnosis that required that you to leave school or attend less than full-time, your licensed physician or health care provider must complete this section.

To the Physician/health care provider:
The student named on this form is an applicant for the NYS scholarship administered by the Higher Education Services Corporation (HESC). For the College to make an eligibility determination, please complete this section in its entirety. Incomplete medical information may result in the denial of the student's application. If additional information is necessary to include, please provide on your letterhead.

1. Was it your medical recommendation that the student stop and/or reduce their college coursework based on his/her medical condition? [ ] Yes [ ] No
2. Please indicate the period when the student's medical condition impacted his/her college attendance:
   [ ] This student/patient needed to stop his/her college studies.
   Effective dates: _____ through _____ OR
   [ ] This student/patient needed to reduce his/her college course load.
   Effective dates: _____ through_____
3. Did the student's medical condition necessitate a change in his/her program of study?
   [ ] Yes [ ] No
4. Did the student change the college he/she attends due to the medical condition?
   [ ] Yes [ ] No
5. Briefly explain how/why this student's medical condition impacted this/her college attendance and if this student has any restrictions upon returning to his/her college studies. **The statement of explanation must be signed and on official office letterhead.**

Physician/health care provider affirmation

By my signature below, I affirm, under the penalty of perjury that the information I provided is true and complete based on my professional medical judgment and the medical records maintained in the ordinary course of business.

Physician/Health Care Provider Signature: _____ Date: _____
Print Name: _____
Professional License#/State: _____
Address: _____
Phone#:_____ Physician's Stamp (required):