



Financial Aid Office  
 Submit form:  
[Document Submission Portal](#) or by mail  
 PO Box 2000, Cortland, NY 13045-0900

### 2026-2027 Excelsior Scholarship Eligibility Appeal Form

Last Name	First Name	MI	C00	Cortland ID#
( )				
Phone Number			Term Appeal is for	

**Complete each of the following steps:**

**Step 1:** Provide a typed statement explaining the extenuating circumstances beyond your control that prevented you from meeting the requirements (completing an average of at least 30 combined credits per year applicable to your degree program and/or continuous enrollment.) Please note that circumstances other than those indicated below do not meet criteria as defined by State Education Law to enable you to retain your award.

Step 2: Check the condition that applies and submit corresponding documentation	
<input type="checkbox"/> I have a disability under the ADA, and I am registered with SUNY Cortland Disability Resources Office.	1. Provide a statement from SUNY Cortland Disability Resources Office on letterhead stating your registration status. a. Personal statement from "Step 1" must include how your disability impeded your ability to complete all required credit hours.
<input type="checkbox"/> I have/had a medical diagnosis that required that I leave school or attend less than full time.	1. Attached "Medical Appeal Form" completed by your physician/health care provider. a. The break in attendance or decrease in credits must coincide with dates from your physician/health care provider. b. Any additional documentation from physician/health care provider must be on official letterhead.
<input type="checkbox"/> I took parental leave	1. Birth Certificate of child a. The break in attendance or decrease in credits must be within one year of newborn's birth.
<input type="checkbox"/> An immediate family member experienced a major medical issue, and I was unable to continue full-time.	1. Ill family member or healthcare proxy must obtain documentation from health care provider stating that family member was under the care of the student. a. Documentation must be on official letterhead and include relationship to patient and dates in which supervision and/assistance was required.
<input type="checkbox"/> I was called to active military duty.	1. Department of Defense Orders a. Personal statement from "Step 1" must include dates of service/deployment.
<input type="checkbox"/> Bereavement – Death of an immediate family member	1. Death Certificate and/or Copy of Obituary a. Personal statement must include your relationship to the deceased. The break in attendance or decrease in credits must coincide with the date the immediate family member died.

**STUDENT AFFIRMATION (Required)**

By my signature below, 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 an affidavit.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_



\_\_\_\_\_  
Last Name                      First Name                      MI                      C00 \_\_\_\_\_  
Cortland ID

**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 Number/State

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone Number

<p><b>Physician's Stamp: (Required)</b></p>
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