

**LINCOLN MEMORIAL UNIVERSITY
CAYLOR SCHOOL OF NURSING
STUDENT APPEAL REQUEST FORM**

PLEASE TYPE OR PRINT LEGIBLY THE INFORMATION REQUESTED BELOW.

Date _____ Telephone _____

Name _____ LMU ID # _____

Address _____

1. Appeal request for: Fall _____ Spring _____ Summer _____ Year _____

2. Course to which appeal is requested: _____

3. LMU campus last attended: _____

4. Situation which you are requesting an appeal: (Be specific regarding your request.)

5. Supporting evidence for the appeal: (You may use back of request form if needed.)

6. Any additional comments: (Limit to the space provided below.)

7. Signature of Student: _____

**PLEASE RETURN THIS REQUEST TO: LMU CAYLOR SCHOOL OF
NURSING, 6965 CUMBERLAND GAP PKWY, HARROGATE, TN 37752**

FOR CAYLOR SCHOOL OF NURSING USE ONLY:

Committee decision: _____

Notification sent to student: _____ Date: _____

Committee Member's Signature/Date: _____
Program Director's Signature/Date: _____