REQUEST FOR AN APPEAL OF THE ELIGIBILITY REVIEW OF A STUDENT - ATHLETE

This form and all supporting information should be faxed or mail to:

PSAL
44-36 Vernon Boulevard, 4th Floor,
Long Island City, NY 11101.

Attention: PSAL Board of Review, Hearing Officer, Fax # 718-729-1106

Case # ________

(PSAL ELIGIBILITY FORM A)

Name Of Student ____________________________________________________________

OSIS Number _______________________________________________________________

Sport ________________________________________________________________

School _________________________________________________________________

Athletic Director __________________________________________________________

Principal ______________________________________________________________

Coach _________________________________________________________________

Contact Info (phone/e-mail/Fax#) ___________________________________________

Submitted By ___________________________ ________________________________

Athletic Director: Print Name ___________ Signature _______________ Date __________

Please provide a brief description of the nature of the review. Attach a copy of the student's transcript and any other pertinent documentation.

Principal's Signature ______________________________________________________

Coach's Signature ______________________________________________________

Parent's Signature ______________________________________________________

FOR COMMITTEE USE ONLY:

Date ___________ Name ________ □ Approved □ Denied □ Due to Rule: _____________

Explanation: