



DE LA SALLE
MEDICAL AND HEALTH SCIENCES INSTITUTE

ACADEMIC SERVICES
THE REGISTRAR
Admissions, Scholarships and Testing

REQUEST FOR RECONSIDERATION

NAME: _____ **DATE:** _____

SCHOOL: _____

SCHOOL ADDRESS: _____

CONTACT NUMBER: _____

EMAIL ADDRESS: _____

For the College Admissions Committee:

Please reconsider my application for reconsideration for college admissions to De La Salle Medical and Health Sciences Institute. Attached are the following photocopied requirements:

1. **Form 138 (Grade 11 & 12 High School Report Card / Form 137 (Transcript of Records))**
2. **CAT / SCAT Result**

If qualified, I would like to be admitted to _____ (course):

Status of Request *(to be filled-out by TRAST)*

☐

Request Approved

☐

Request Disapproved

Remarks:

For and on behalf of the Collegiate Admissions Committee:

The Registrar – Admissions, Scholarships and Testing Section

Date

Note: Accomplish in two copies (1-TRAST; 2. Applicant's Copy)