Dispute Resolution Form
Florida Atlantic University Schools

Name of Student: _____ Date: _____

School: _____ Parent/Guardian: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (___)_____ Work Phone: (___)_____

State the nature of your dispute. Identify any person(s) you believe may be involved. (Use an additional sheet of paper if necessary.)

Completed form should be submitted within TEN (10) school days of the occurrence.

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Please provide any corrective action you wish to see taken with regard to this issue. You may also provide other information relevant to this dispute.
(Use a separate sheet of paper if necessary.)

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Signature: Parent/Guardian **Date**

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Signature of Person Accepting Dispute Resolution Form **Date Received**