REQUEST FOR POSTGRADUATE STUDENTS

1. First Name: …………………………………………………………………………………

2. Middle Name………………………………………………………………………………

3. Surname……………………………………………………………………………………

4. Year entered ………… Completion year ………… Sex …………

5. Completion Date: May/June ☐ November/December ☐

Select type of letter:
- Dean’s Letter
  - Residency in ……………………………………..
    (Specialty)
  - Fellowship in …………………………………..
    (Specialty)
- License to practice
- Verification of Language of Instruction
- Verification of Internship
- Other __________________________

6. Did you complete internship? ☐ Yes ☐ No

7. Hospital(s) __________________________ Period? ______________________________

8. Areas covered during internship?
- Surgery ☐ Medicine ☐ Paediatrics ☐ Orthopaedics ☐ Plastic Surgery
- A&E ☐ O&G ☐ Dermatology ☐ ENT
- Others ______________________

9. Are you registered with the Jamaica Medical Council? ☐ Yes ☐ No

10. Addressee
- To Whom it May Concern
- Other ________________________________

Requested by __________________________ Date __________________

Contact# __________________________ Fax # __________________

E-mail address ________________________________________________

N.B. Administrative charge of $1000.00 per copy. Please note that there is a fee for courier service if required. This will have to be confirmed with the Office as this is not a set amount. Send form to fmsundergrad@uwimona.edu.jm