THE UNIVERSITY OF THE WEST INDIES

MEDICAL CERTIFICATE/REPORT
(Coursework and Final Examinations)

To be completed by Medical Officer and submitted in accordance with University regulations (21) (ii) which states that in cases of illness the candidate shall present to the Campus Registrar a medical certificate as proof of illness, signed by the University Health Officer or by any approved medical practitioner. The candidate shall send the medical certificate within seven days from the date of that part of the examination in which the performance of the candidate is affected.

PART A – TO BE COMPLETED BY STUDENT:

Surname__________________________ First Name__________________________

Student ID#__________________________ Faculty__________________________

Academic Year__________________________ Semester I□ Semester II□

Course-Work□ Mid-Term□ Summer/Resit□ Final Exam□ General/Other□

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I,__________________________, hereby authorize Dr./Mr./Ms.__________

to provide the following information to the Student Medical Officer, The University of the West Indies and, if required to supply additional information to support my request for academic consideration for medical reasons. My personal information will be used for administrative and academic record-keeping, academic integrity purposes and the provision of services to students.

__________________________ Date (yy/mm/dd)

MEDICAL CERTIFICATES MUST BE SUBMITTED WITHIN SEVEN (7) DAYS FROM THE DATE OF EXAMINATION.
PART B – TO BE COMPLETED BY PHYSICIAN:

1. I hereby certify that I provided Health Care Services to the above named student on

   Insert date(s) student seen in your office

2. The student could not reasonably be expected to complete academic responsibilities for the following reasons:

   __________________________________________
   __________________________________________
   __________________________________________

3. This is an  [ ] acute /  [ ] chronic problem for this student.

4. Unable to complete academic responsibilities for:

   [ ] days                [ ] months
   [ ] weeks               [ ] other (please indicate)________________________

   DATES: From________________________ to ________________________

5. If the student is permitted to continue his/her course of study, is the medical problem likely to recur and affect his/her studies again?    Yes  [ ] No  [ ]

   Reason: ________________________________________________
   ________________________________________________

6. If the student is permitted to continue his/her course of study, are there any accommodations, restrictions or special conditions that need to be followed?

   [ ] Yes  [ ] No

   If yes, provide details:______________________________________
   ________________________________________________
   ________________________________________________

PHYSICIAN VERIFICATION

Name : (please print) ___________________________    Registration No._________________

Signature: ____________________________________    Telephone No.____________________

Stamp: ________________________________________