School of Pharmacy

Application for Deferred FINAL Examination or Reallocation of Marks

Name: _________________________ Student Number: _________________________
MUN e-mail: ___________________ Semester (Term & Year): ___________________

Application for Deferred Exam ☐  OR  Mark Reallocation ☐

<p>| Course for which application is being made (a separate form is required for each request) |
|---------------------------------|----------------|----------------|----------------|</p>
<table>
<thead>
<tr>
<th>Course Number</th>
<th>Course Name</th>
<th>Course Coordinator</th>
<th>Date of Scheduled Exam</th>
</tr>
</thead>
</table>

Reason for Request: ______________________________________________________________________
_______________________________________________________________________________________
_______________________________________________________________________________________

**If absence is due to medical reasons, the attached Student Medical Certificate must be completed by the attending physician**

Processing of Application:
1. Student submits application along with appropriate supporting documentation (e.g.: medical certificate, death notice/certificate) to the School’s Associate Dean (Undergraduate) and copies the course coordinator. *(Application must be made as soon as possible but no later than 48 hours after the exam date.)*
2. Application will be considered by the Associate Dean and the Course Coordinator.
3. Student will be informed of the decision on the application via email as soon as one is rendered.
4. A copy of the application and the decision will be forwarded to the Manager of Academic Programs to be placed in the student file.

5. 

For Office Use Only

_________ Request Approved ________ Request Denied ________ Additional Documents Requested

Comments: _____________________________________________________________________________
_______________________________________________________________________________________

Deferred Exam Offered. Date: _______________ Time: _____________ Location: ____________

OR

☐ Marks Reallocated.

Date: ___________  ______________  Associate Dean, (Undergraduate) School of Pharmacy

Date: ___________  __________________  Course Coordinator

Memorial University protects your privacy and maintains the confidentiality of your personal information. The information requested on this form is collected under the authority of the Memorial University Act (RSNL 1990 Chapter M-7) and is needed for and will be used for the purpose of processing your application for a deferred examination(s) and for administrative purposes. Questions about this collection and use of personal information may be directed to the School of Pharmacy Privacy Officer at (709)777-7211.

Revised: June 29, 2017
STUDENT MEDICAL CERTIFICATE

I

TO BE COMPLETED BY STUDENT: STUDENT NUMBER: ___________________________

I, ___________________________, hereby authorize this health care professional to provide the following information to Memorial University.

_________________________________________  ________________________________
Signature                                      Date

II

TO BE COMPLETED BY HEALTH CARE PROFESSIONAL:

I hereby certify that I provided health care services to ___________________________, a student at Memorial University, on [Date(s)] ________________________________. On the basis of that episode of care, I am providing the following information for use by the University in assessing what special consideration, if any, should be given to the student in respect of the application of University regulations, including the approval of deferred final examinations.

1. the degree to which the health issue (or treatment, in the case of medication, for example) is likely to have affected the student’s ability to study, attend classes, or sit examinations.

   __________________________________________________________________________

   __________________________________________________________________________

   __________________________________________________________________________

2. the length of time over which the student’s abilities were likely hampered by the condition (e.g., recurring and severe back pain over a two-month period would likely have a more adverse effect on studies than a single episode of back pain requiring bed rest for a week).

   __________________________________________________________________________

   __________________________________________________________________________

   __________________________________________________________________________

3. the fitness of the student to resume studies (it is in the student’s best interest not to return to studies prematurely).

   __________________________________________________________________________

   __________________________________________________________________________

   __________________________________________________________________________

VERIFICATION BY HEALTH CARE PROFESSIONAL:

_________________________________________  ________________________________
NAME (PLEASE PRINT)                      SIGNATURE

ADDRESS (STAMP, BUSINESS CARD OR LETTERHEAD ACCEPTABLE)

_________________________________________  ________________________________
TELEPHONE                                  DATE

PLEASE RETAIN COPY FOR THE PATIENT’S CHART.