



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 []

Table with 4 columns: Course Number, Course Name, Course Coordinator, Date of Scheduled Exam

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...
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.



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 ACCEPABLE)

TELEPHONE

DATE

PLEASE RETAIN COPY FOR THE PATIENT'S CHART.