THE UNIVERSITY OF THE WEST INDIES
CAVE HILL CAMPUS
STUDENT HEALTH CLINIC
Tel: (246) 417-4170

Medical Certificate/Report

(Coursework and Final Examinations)

To be completed by Medical Practitioner and submitted to the Medical Health Officer, Cave Hill Campus in accordance with University Regulations (21) (ii) which states that in cases of illness the candidate shall present to the Campus Registrar or in the case of candidates in the Open Campus through the HEAD, SITE COORDINATOR or TLI a medical certificate, as proof of illness, signed by the University Health Officer or by any other medical practitioner approved for this purpose by the University. 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. A certificate received after this period will be considered only in exceptional circumstances.

PART A – TO BE COMPLETED BY STUDENT:

Surname _____ First Name _____

Student ID# _____ Faculty _____

Semester _____ Postgraduate ◉ Undergraduate ○

Coursework ☐ Mid-Term ☐ Final Exam ☐ General/Other ☐ _____

COURSE CODE	COURSE TITLE	DATE (yy/mm/dd)	TIME

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 record-keeping, academic integrity purposes and the provision of services to students.

_____ _____
Signature (Student) Date (yy/mm/dd)

MEDICAL CERTIFICATE MUST BE SUBMITTED TO THE STUDENT HEALTH CLINIC WITHIN SEVEN (7) DAYS FROM THE DATE OF EXAMINATION.

TO BE COMPLETED BY STUDENT HEALTH CLINIC

MEDICAL CERTIFICATE RECEIPT TO BE DETACHED AND GIVEN TO STUDENT

NAME OF STUDENT: _____

ACCEPT / DENIED:
(Medical Health Officer) _____

SIGNATURE OF RECIPIENT:
(Student Health Clinic) _____

DATE RECEIVED BY STUDENT HEALTH CLINIC: _____

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. Date (s) during which student claims to have been affected by this problem:

   _____

5. Unable to complete academic responsibilities for:

   ☐ 24 hours ☐ 2 days

   ☐ 3 days ☐ 4 days

   ☐ 5 days ☐ Other (please indicate) _____

DATES: From_____ to _____
(yy/mm/dd) (yy/mm/dd)

6. 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:_____

   _____

   _____

   _____

7. 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:_____