



**THE UNIVERSITY OF THE WEST INDIES
ST AUGUSTINE CAMPUS**

HEALTH SERVICES UNIT
Telephone: (868) 662-2002 Exts. 2149/2153
Website: www.sta.uwi.edu/health/

**MEDICAL CERTIFICATE/REPORT
(Coursework and Final Examinations)**

To be completed by Medical Officer and submitted to the Head, Medical Unit, St Augustine Campus 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 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.

PART A – TO BE COMPLETED BY STUDENT:

Surname _____ First Name _____
Student ID# _____ Faculty _____
Academic Year _____ Semester I Semester II
Summer/Resit

DATE	TIME	COURSE CODE	SUBJECT

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.

Signature Date (yy/mm/dd)

MEDICAL CERTIFICATES MUST BE SUBMITTED WITHIN SEVEN (7) DAYS FROM THE DATE OF EXAMINATION.



TO BE COMPLETED BY HEALTH SERVICES UNIT
MEDICAL CERTIFICATE RECEIPT TO BE DETACHED AND GIVEN TO STUDENT

NAME OF STUDENT: _____

COURSE CODE (S): _____

SIGNATURE OF RECIPIENT: _____

(Health Services Unit)
DATE RECEIVED BY HEALTH SERVICES UNIT: _____

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 _____

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: _____