The University of The West Indies
Cave Hill Campus
The Faculty of Medical Sciences

APPLICATION FOR LEAVE OF ABSENCE FROM THE UNIVERSITY

Student Name: Date:

Student ID#: Level: -

Phone#: Academic Year 20 /20
(best number to contact you)

Degree Programme: None

Type of Leave request:

Short Leave: 1-14 days ☐ 1 Month ☐ From: To:

Long Leave: Semester 1 Only ☐ Semester 2 Only ☐ Academic Year ☐

Please give a brief explanation why you are requesting Leave of Absence:

I understand that my request for leave of absence must be received on or before the registration period is closed. Failure to submit my request on or before the period may result in my leave of absence request being denied. Kindly note this does not apply to persons requesting short leave.

Signature: Date:

Programme Coordinator: Signature/Initials

OFFICE USE ONLY

Signature: Supported ☐ Not Supported ☐ Date:
Head of Department

Comments:

Leave Approved ☐ Leave Not Approved ☐

Dean's Signature: Date:

Return Form to the Office of Undergraduate Affairs & Medical Education
Email: fmsundergradoffice@cavehill.uwi.edu