

**MEDICAL STUDENT REQUEST FOR CHANGE OF EXAMINATION DATE  
(YEARS 1 & 2)**

STUDENT'S NAME: \_\_\_\_\_ TODAY'S DATE \_\_\_\_\_

EMAIL ADDRESS \_\_\_\_\_ CELL PHONE \_\_\_\_\_

COURSE TITLE: \_\_\_\_\_ DATE OF EXAM: \_\_\_\_\_

1<sup>ST</sup> CHOICE OF RESCHEDULED DATE: \_\_\_\_\_

2<sup>ND</sup> CHOICE OF RESCHEDULED DATE: \_\_\_\_\_

REASON FOR REQUESTING A CHANGE OF EXAMINATION DATE/TIME

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

IF IT IS FOR A MEDICAL REASON, IS A DOCTOR'S LETTER ATTACHED? \_\_\_\_\_ YES \_\_\_\_\_ NO

I FEEL THIS IS A LEGITIMATE AND RESPONSIBLE REASON FOR BEING GRANTED PERMISSION TO CHANGE THE DATE OF THE ABOVE EXAMINATION.

\_\_\_\_\_  
STUDENT'S SIGNATURE

**PLEASE COMPLETE THIS FORM AND SUBMIT IT TO THE SCHOOL OF MEDICINE AND HEALTH  
SCIENCES DEAN'S OFFICE FOR APPROVAL.**

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**DEAN'S OFFICE APPROVAL**

SIGNED: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

COMMENTS:

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