



**University of Manitoba
Max Rady College of Medicine
Undergraduate Medical Education Program**

Application for Deferred Examination

NAME:	STUDENT #:
ADDRESS:	
CITY:	POSTAL CODE:
PHONE #: (home): _____ (cell): _____	EMAIL : _____

From which type of examination are you requesting a deferral?

Modular Examination _____	Course Name _____
NBME Examination _____	Rotation Name _____
OSCE-type Examination _____	OSCE-type Examination Name _____

Date of scheduled examination: _____

REASON FOR REQUEST OF A DEFERRED EXAMINATION (CHECK ONE)	
MEDICAL _____	Medical Certificate Attached: _____ Date: _____
OTHER _____	If for other reason(s), provide details on reverse side of this form and attach documentation in accordance with the Deferred Examination Policy.

Date: _____ **Signature:** _____

Statement of Purpose: This personal information is being collected under the authority of *The University of Manitoba Act*. It will be used to obtain information related to the student's request for deferred examination(s), and to assess whether deferred examination(s) should be granted. It will not be used or disclosed for other purposes, unless permitted by *The Freedom of Information and Protection of Privacy Act*. Your personal information is protected by the Protection of Privacy provisions of *The Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection of your personal information, contact the Access & Privacy Coordinator's Office (tel. 204- 474-9462 or 204-474-8757), 233 Elizabeth Dafoe Library, University of Manitoba, R3T 2N2.

THE PORTION BELOW TO BE COMPLETED BY THE ASSOCIATE DEAN, STUDENT AFFAIRS	
COMMENTS:	
_____ (Date)	_____ (Signature of Associate Dean, Student Affairs)

