

**DEPARTMENT OF COMPUTER SCIENCE
MEMORIAL UNIVERSITY OF NEWFOUNDLAND**

Application for Deferred Exam

First Name _____ Last Name _____

MUN Student Number _____ Current Semester and Year _____

Email (@mun.ca email address only) _____

Course Number	Section Number	Name of Instructor	Date/ Time of Exam
COMP-			

Please indicate the reason for requesting a Deferred Exam:

Medical	Bereavement	Three exams in 24 hours
Other: _____		

1. For an application to be considered, proper supporting documents must be attached (as per University Calendar regulation 6.8.2). For medical, students should provide the health professional with Memorial's *Student Medical Certificate* form to complete.
2. This completed application and supporting documents should be emailed to cs-ugradadv@mun.ca in accordance with University deadlines (as per University Calendar regulation 6.8.2). Application should be made in advance of the exam wherever possible, but no later than 48 hours after the original date of the exam.
3. Results of this application will be sent to the student's MUN email address only. If the application is approved, the student must then contact their instructor to arrange a mutually convenient time to write the deferred exam.

FOR OFFICE USE:	<input type="checkbox"/> Approved	<input type="checkbox"/> Not Approved
Head's Signature (or delegate): _____ Date: _____		
Copy: Instructor Registrar's Office		

ID#1 Deferred Exam Notice: Memorial University protects your privacy and maintains the confidentiality of your personal information. The information requested on this form is collected under the authority of the Memorial University Act (RSNL 1990 Chapter M-7) and is needed for examination(s) and for administrative purposes. Questions about this collection and use of personal information may be directed to the Office of the Department Head at (709) 864-8652.