



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#:

Year:

Phone#:

Academic Year 20\_\_/20\_\_

(best number to contact you)

Degree Programme:

Type of Leave request:

Short Leave: 1-14 days

1 Month

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:

**OFFICE USE ONLY**

Signature:  
*Programme Coordinator*

Supported

Not Supported

Date:

Comments:

Leave Approved

Leave Not Approved

Dean's Signature:

Date: