

# REQUEST FOR MSPE

1. First Name: .....
2. Middle Name.....
3. Surname.....
4. Year entered ..... Completion year ..... Sex .....
5. Completion Date: May/June  November/December

Kindly send information below that was completed during and related to Medical School. Any other information that you desire to be included that was done outside of the University, please provide proof of such information. Send information to [fmsundergrad@uwimona.edu.jm](mailto:fmsundergrad@uwimona.edu.jm).

- Leadership position(s) held while in medical school
- Extra-curricular activities or
- Research participated in.

Requested by \_\_\_\_\_

Date Requested \_\_\_\_\_

Contact # \_\_\_\_\_

Fax # \_\_\_\_\_

E-mail address \_\_\_\_\_

Send form to (if applicable):

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

**N.B. Administrative charge of \$2500.00 per copy. Please note that there is a fee for courier service if required. This will have to be confirmed with the Office as this is not a set amount.**

**Kindly complete the table below indicating the periods for the clerkships completed:**

Clerkship	From	To
1. Junior Medicine		
2. Junior Surgery		
3. Aspects of Family Medicine		
4. Anaesthesia		
5. Junior Community Health		
6. Dermatology		
7. Emergency Medicine		
8. Medicine and Humanities		
9. Obstetrics and Gynaecology		
10. Ophthalmology		
11. Orthopaedics		
12. ENT (Otolaryngology)		
13. Pathology and Microbiology		
14. Psychiatry		
15. Radiology		