REQUEST FOR POSTGRADUATE STUDENTS

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

Select type of letter:

- ❑ Dean's Letter
  - Residency in …….
    (Specialty)
  - Fellowship in …….
    (Specialty)
- ❑ License to practice
- ❑ Verification of Language of Instruction
- ❑ Verification of Internship
- ❑ Other _____

6. Did you complete internship? ☐ Yes ☐ No
7. **Hospital(s)_____Period?_____**
8. **Areas covered during internship?**
   ☐ Surgery ☐ Medicine ☐ Paediatrics ☐ Orthopaedics ☐ Plastic Surgery
   ☐ A&E ☐ O&G ☐ Dermatology ☐ ENT

   Others_____
9. **Are you registered with the Jamaica Medical Council?** ☐ Yes ☐ No
10. **Addressee**
    - ❑ **To Whom it May Concern**
    - ❑ **Other** _____

    _____

Requested by_____ Date_____

Contact# _____ Fax #_____

E-mail address _____

N.B. Administrative charge of $1000.00 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. Send form to fmsundergrad@uwimona.edu.jm