

MEDICAL REPORT FORM FOR ABSENCE FROM UNDERSTANDING TEST



NOTES (To the Student):

1. Students are required to submit the completed Medical Report Form together with the original medical certificate to the One-Stop Centre within three working days from the last date of absence. Any forms received without the original medical certificate will not be accepted. (For MCs issued by government Polyclinics or restructured hospitals/specialist clinics, the requirement for this Medical Report Form is waived.)
2. Students who are absent from Understanding Test 3 (UT 3) due to illness are required to report their illness to the Office of the Registrar by sending an email to help-registrar@rp.sg within twenty-four hours of the first UT 3 missed, failing which they may not be allowed to take a supplementary Understanding Test 4 (UT 4).
3. Part 1 of this form must be fully completed by the student before presenting it to the registered medical practitioner attending to him/her.
4. Only a registered medical practitioner is authorised to complete Part 2 of this form.

PART 1 - PARTICULARS OF STUDENT												
Full Name in BLOCK LETTERS	Student ID	NRIC/FIN <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>										
Diploma in:	Contact Telephone Number											
Affected Understanding Test Module Code:	Date and Time of Understanding Test:											
Declaration by the Student I hereby declare that the information provided above is true and that I am applying for Leave of Absence for the Understanding Test indicated above due to illness.												
_____		_____										
Signature of Student		Date										

PART 2 – CERTIFICATION BY REGISTERED MEDICAL PRACTITIONER		
The student _____ (Student's Full Name) of		
NRIC/FIN: _____ has visited me on _____ (date of visit).		
I certify that the student is fit/unfit* to take the Understanding Test (Examination) held on _____ (date of test)		
at _____ (time of test).		
Comments, if any:		

_____	_____	_____
Name and Signature of Medical Practitioner	Hospital/Clinic Stamp	Date
<i>*please delete accordingly</i>		