

INTEGRATED BIOMEDICAL ENGINEERING AND HEALTH SCIENCES PROGRAM iBioMed Advisement

REQUEST FOR DEFERRED EXAM PRIVILEGES

DATE: STUDENT NAME: PROGRAM:	DENT NAME:		Fall Winter STUDENT NUMBER:		Spring/Summer
CONTACT ADDRESS:				LEVEL:	
_	No.	Street		City	Postal Code
McMASTER EMAIL:			PHONE NUMBER:		
Reason for failure to write the examination(s):					
(-)					
COURSE NAME & TERM WATERWATER				SIGNATURE*	
COURSE CODE	TERM	INSTRUCTOR	DATE 8	TIME OF EXAM	(see NOTE below)
*NOTE					
(i) THIS FORM MAY ONLY BE USED IF YOU DID NOT SIT FOR THE FINAL EXAMINATION OR ANY PART THEREOF.					
(ii) I confirm that I have completed all other requirements for this course and have done well enough to pass the course if my deferred examination is granted.					
(iii) I understand that approval for a deferred examination will be rescinded if the above are found to be untrue.					
(iv) A deferred examination may only be granted once for a particular course. Deferred examinations will be written in the next deferred examination period. Failure to write the deferred examination will result in a course grade based on a					
mark of zero in the final exam.					
 (v) I understand that it is my responsibility to check my McMaster Email account to confirm that my application has been approved. (vi) The Office of the Registrar will send an email with my individual deferred examination schedule, to my McMaster account, 					
(vi) The Office of the Registrar will send an email with my individual deferred examination schedule, to my McMaster account, approximately two weeks prior to the examination session. I am responsible for ensuring that I check my McMaster email					
account. It is my responsibility to know where and when the exam is being held.					
FOR OFFICE USE ONLY:					
☐ Approved by the Reviewing Committee ☐ Not approved by the Reviewing Committee					
Authorizing Signature:	l	Date:			
			- **** :		

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