RAI MEDICAL COLLEGE SARGODHA

STUDENTS LEAVE FORM:

Name: ____

Roll No:__________________________ **Year:** ______________________________________

Period from: _________________ **To:** ___________ **No of Day's:**______________________

Dates of previous leaves if availed:____

Reason for Leave: ____

Address while on leave: ____

Contact No: ____________________________________

Signature of Applicant: ___________________________

Date: _________________________________

Remarks by Senior Class Teacher: __________________ **Sig:** _____________________

☐ **Approved** ☐ **Not Approved** **Principal**

Sig ________________________

Date: ______________________