

Faculty of Dental Sciences
University of Sri Jayewardenepura
Student Request Form

1. Name :
2. Batch :
3. Registration No. :
4. Examination Index No.:
5. Contact No. :
6. Request:

Reason	Please tick (✓)
Submit a medical certificate	
Other (please specify).....	

7. If it is for submit a medical certificate:

- i. Medical Certificate issued by:
- ii. From : to:
- iii. No. of days :

8. Details regarding the Examination/ Tutorial/ Practical dates and the Departments relevant to the request:

Examination		Tutorial		Practical		Department
Subject	Date	Subject	Date	Subject	Date	

.....
Signature of the Student

.....
Date

Recommendation of the Phase Coordinator

- Supporting documents cover the relevant period: Yes/ No/ Not Applicable
- Recommendation: Recommended/ Not Recommended

.....
Signature of the Phase Coordinator

.....
Date

For Office Use Only

- Received by :.....
- Received on :.....

Checked with the original documents and found correct.

Signature of the Subject Clerk:.....

.....
Assistant Registrar
Faculty of Dental Sciences

.....
Date