Najran University
College of Dentistry
Dental Internship Training Program

LEAVE REQUEST APPLICATION

Interns Name	
University Number	
Training Center	
Email	
Mobile No	

Number of leave days	
Start Date	
End Date	
Reason:	***please attach supporting documents*
Emergency	
**Interview	
**Examination	
Conference/Workshop	
Others	
Signature	
Sent by email	
Date of email	
Remaining Leave Credits	

☐ APPROVED

☐ NOT APPROVED
Reason:

Director of Clinics :
Name :
Signature:
Date :

☐ APPROVED

☐ NOT APPROVED
Reason:

Interns' Program Director:
Name:
Signature:
Date :