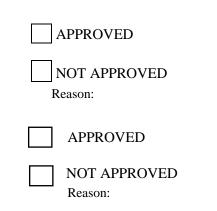


Najran University College of Dentistry Dental Internship Training Program

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	



Interns' Program Director: Name:

Signature: Date :

Directorof Clinics :Name:Signature::Date: