



SWAMI ATULANAND HINDU MAHAVIDYALAY

Parmanandpur, Shivpur, Varanasi 221002

MEDICAL LEAVE APPLICATION FORM

Name of Student:		Roll/Enrollment No.:	
Course/Programme:		Year/Semester:	
Mobile No.:		Class/Section:	

Leave required from: _____ To: _____ Total days: _____

Reason / Medical condition (brief):

Doctor/Hospital Name: _____

Medical Certificate enclosed: ☐ Yes ☐ No

I request leave for the above period and will resume classes after recovery.

Date: _____

Student Signature: _____

Approved By-

HOD: _____

Principal/Authorized Signature: _____