

M. L. S. M. COLLEGE, DARBHANGA

(A CONSTITUENT UNIT OF L. N. MITHILA UNIVERSITY, DARBHANGA)

Website: www.mlsmcollege.ac.in, E-mail: mlsmcollege@gmail.com



Letter no.....

Dated.....

MEDICAL LEAVE APPLICATION FORM

1. Name of the Applicant: _____
2. Designation of the Applicant: _____
3. Department/Section: _____
4. Number of Days applied for leave: _____ 5. Date of Leave (From _____ To _____)
6. Nature of Illness: _____
7. Whether Medical Certificate is attached: YES or NO
8. Name of Doctor/Hospital: _____
9. Contact Number during leave: _____
10. Academic/Work arrangement during absence
 - a) My class will be engaged by the faculty (.....)
 - b) I will take additional classes after returning from leave, if needed.
 - c) I have already taken additional classes before this leave.

I certify that the medical certificate attached is genuine and the leave applied is for the illness mentioned above.

Full Signature of the Applicant: _____

Dated by: _____

=====FOR OFFICE USE=====

Signature of HOD: _____ Date: _____	Signature of Principal: _____ Date: _____ College Stamp with Date:
--	--