Registration Suspension Request Form

FACULTY OF HEALTH SCIENCES
TO THE HEAD OF …… DEPARTMENT

In accordance with the relevant article of our University's Education–Training and Examination Regulations, I request to suspend my registration for the period specified below due to the reason stated.

I respectfully submit this request for necessary action..

Date : … / … / 20..
Name Surname :
Signature :

Please fill in all fields.

Student Number	
Department	
Mobile Phone	
E-mail Address	
Academic Year	… /…
Course Term	☐ FALL ☐ SPRING

Reason for Registration Suspension	
How Many Semesters Would You Like to Suspend Your Registration?	☐ 1 Semester ☐ 2 Semesters

Attachment:

1. **Document Stating the Reason**

Advisor Approval
Date : … / … / 20..
Name–Surname: :
Signature :