



KUWAIT INSTITUTE FOR MEDICAL SPECIALIZATIONS

POSTGRADUATE EDUCATION OFFICE

LEAVE OF ABSENCE REQUEST FORM

NAME : _____ (IN BLOCK LETTERS)													
CIVIL IDENTIFICATION NUMBER: <table border="1"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr></table>													
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NAME OF PROGRAM: _____	(Tick <input checked="" type="checkbox"/> your current level. R=Residency, F=Fellowship) R1 <input type="checkbox"/> R2 <input type="checkbox"/> R3 <input type="checkbox"/> R4 <input type="checkbox"/> R5 <input type="checkbox"/> F1 <input type="checkbox"/> F2 <input type="checkbox"/> F3 <input type="checkbox"/>												
KINDLY SPECIFY YOUR REASON/S FOR LEAVE OF ABSENCE: (PLEASE ATTACH SUPPORTING DOCUMENTS) STARTING DATE OF LEAVE: _____ ENDING DATE OF LEAVE: _____													
DATE : _____ (of submission by Candidate)	SIGNATURE: _____ (Candidate)												
DATE : _____ (of approval by Program Director)	SIGNATURE: _____ (Program Director)												
DATE: _____ (of approval by Director Postgraduate Education Office, KIMS)	SIGNATURE: _____ (Director Postgraduate Education Office, KIMS)												