ADVENTIST UNIVERSITY OF CENTRAL AFRICA
P. O. BOX 2461, KIGALI, RWANDA

CLAIM FORM

For Last Semester

(To be filled in Triplicate: For the Department, Registrar and Student)

Student Name: …… ID No. ……

Tel. No.(s) …… Email Address: ……

Faculty: …… Department: ……

Program (Day/Evening): ……

Course/Claim: (attach clear evidence of the claim): ……

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Concerned Department: ……

Instructor/Person Concerned: ……

Student's Signature: …… Date: ……

To be Filled by the Department

Received by: ……

Position: ……

Signature: …… Date: ……

Observation by the Department or Person Concerned: ……

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Signature: …… Date: ……

Answer from HOD: ……

Communicated to the Student by: ……

Observation of the Student: ……

Student's Signature: …… Date: ……