



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

SUSPENSION/WITHDRAWAL FORM

Student Name: ID No.

Faculty: Department:

Date: Academic Year: Semester: 1 2

Reason for Suspension/Withdrawal:

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Note: Have this form signed by the following:

1. Dean of Faculty

Observation: Signature: Date:

2. Librarian

Observation: Signature: Date:

3. IT Administrator

Observation: Signature: Date:

4. Director of Student Services

Observation: Signature: Date:

5. Business Manager/Chief Accountant

Observation: Signature: Date:

6. Registrar

Observation: Signature: Date:

Date of Reintegration: