



Kirinyaga University

EXAMINATION OFFICE

SPECIALS EXAMINATION REQUEST FORM

Name: Reg. No.:
 School: Department:
 Programme: Academic Year:
 Year & Semester of Study: Year & Month of Admission:
 Scheduled Examination Date: Telephone Contact:
 Email:

Examinations Requested:

	Unit Code	Unit Name
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Reasons for Application:

Medical grounds (Attach medical report)
 Financial grounds (Attach current fee statement)
 Other reasons (Attach relevant evidence)

Student Signature: Date:

CoD's Comments:

Name: Signature: Date:

Dean's Remark: (Recommended/ Not Recommended)

Name: Signature: Date:

Deans Committee Decision: (Approved/ Not Approved)

Verified: Signature: Date:

Registrar, ASA

