SA/15

Kuwait University
College of Graduate Studies

Treatment Request for Graduate College Students

To be filled by student

Name: Civil ID:

Program: College:

Resident Area (According to Civil ID):

Student Service Department

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Treating Physician's Use

Health Center/Clinic: ______________________ Date: ____________

Diagnosis and Recommendation:

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Clinic Stamp	Physician's Stamp & Signature	Hospital Director
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Note: Please adhere to visit the designated health center according to the residence area shown on the Civil ID.