(Form No. 2)

Seal of the Professor	
Seal of the Supervisor	

Request for Cancellation of Leave of Absence 【休学取消願】

Date:	year	month	day	

To: Dean of Graduate School of Medicine

	Graduate School of Medicine Department	artment
	Yearadmitted/advanced/tran	sferred:year student
	Student ID No.	
	Name	(Signature)
	Address \top (Mobile) Phor	ne
	E-Mail	
I hereby request cancellation of my appro- yearmonthday) for the		monthdayTO
Reason:		

Note 1: After you submit a request, if you do not receive any response from the university before the date of the leave of absence is due to begin, it means that your request has been approved.

^{2:} Signature may be replaced by printed name and seal.