



UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

EXAMINATION REQUEST

STUDENT NAME (Please print) _____

DDS Year _____ STUDENT # _____

Please provide me with a copy of my examination(s) as follows:

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Course	Month/Year Date Written
_____	_____
Course	Month/Year Date Written
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I understand that this service costs \$13.00 and that this fee is non-refundable.
I will return to collect the paper after five working days.

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DATE

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