



UNIVERSITY OF TORONTO
FACULTY OF DENTISTRY

Date _____

Student Name: _____

Student Number: _____ Class _____

E-mail address:
(mail.utoronto.ca address only) _____ (Year 1, 2, 3, 4)

Course Director Name and Email address (associated with request, utoronto.ca address only):

Petitioners Request:

Specific Course/Lab/Clinical Sessions, dates, and assignments and/or assessments missed (as applicable):

Reasons why petitioner considers above request should be granted (if space provided is not sufficient, feel free to add an addendum with additional information):

Signature _____

Your statement should be as complete and brief as possible. Return to the Student Services, Room 104.

STUDENT SERVICES OFFICE

104 - 124 Edward Street, Toronto/Ontario/ M5G 1G6 Canada

Tel: +1 416 979-4901 • Fax: +1 416 979-4944 • <http://www.dentistry.utoronto.ca>