UNIVERSITY OF IRINGA

FREEZING OF STUDIES REQUEST FORM

(To be filled in duplicate BY POSTGRADUATE STUNDENTS ONLY)

1. Personal Information
   Surname: ______________________ First Name ______________________ Middle Name _________________
   Registration No: ______________________ Year of Entry________ Expected Year of Completion ________
   Year of Study (e.g. 1st, 2nd): _____________ Semester: ______________ Academic Year: _________________
   Faculty: ______________________________________ Department: ___________________________________
   Programme: ____ Specialty: ____________________________
   Mobile No: ___________________________ Email address(s): ______________________________________
2. Reasons for Freezing (*Please tick the appropriate box*)

Medical		**Financial**		**Social**		**Others**	

   Briefly explain (*and attach evidences*)
   ____
   NOTE: *No student is allowed to freeze studies if the student has not completed coursework*
3. Freezing Period Sought (*Maximum freezing period is only one (1) academic year*)
   Number of Semesters _______ Starting Date: _________________________ to ________________________
4. Postponement History
   1st Freezing: From ______________________ to _____________________
   2nd Freezing: From ______________________ to _____________________
   (You will be required to attach a complete signed copy of this form on your application to resume studies)
   Date of Application _____________________________ Signature _________________________

For OFFICIAL USE ONLY (Authorization for Freezing of Studies)

5. Recommendations by the Dean of Students
   ____
   ____
   Name ____ Signature ________________ Date________________
6. Recommendations by the Head of Department
   ____
   ____
   Name ____ Signature ________________ Date________________
7. Recommendations by the Dean of Faculty
   ____
   ____
   Name ____ Signature ________________ Date________________
8. Recommendations by the Director of Postgraduate Studies, Research, and Consultancy
   ____
   Name ____ Signature ________________ Date________________
9. Approval by the DVC ARC
   ____
   Name ____ Signature ________________ Date________________

Copy to file
Dean Faculty ___ Head of Department ___ Admission Officer____ Dean of Students___ SAMIS Admin__