

UNIVERSITY OF MEDICAL SCIENCES, LAJE ROAD, ONDO, ONDO STATE



STAFF CLEARANCE FORM

STAFF NAME

STAFF NUMBER

FACULTY/DIVISION

DEPARTMENT

PHONE NUMBER

EFFECTIVE DATE OF RESIGNATION

S/N	AUTHORITY	OFFICER'S NAME	SIGNATURE	DATE
1.	HEAD OF DEPARTMENT/UNIT			
2.	UNIVERSITY LIBRARY			
3.	ICT			
4.	UNIVERSITY HEALTH SERVICES			
5.	CHIEF SECURITY OFFICE			
6.	DIRECTOR OF WORKS AND SERVICES			
7.	UNIMED STAFF CMS			
8.	INTERNAL AUDIT			
9.	BURSARY			
10.	HUMAN RESOURCE OFFICE			

This is to certify that the above named staff has fulfilled all the necessary obligations to the University and hence been duly cleared to leave the University.

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Registrar

Stamp

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Date