

**UNIVERSITY OF MEDICAL SCIENCES (UNIMED),  
LAJE ROAD, ONDO CITY, ONDO STATE.**



**OFFICE OF THE REGISTRAR  
RESUMPTION FROM RESEARCH LEAVE FORM**

Leave Year ..... Staff Number .....

Full Name (Surname Last) .....

Designation .....

Department/Faculty .....

Number of leave days/weeks .....

Date embarked on Leave .....

Date of Resumption from Leave .....

Did you fully utilize your leave? Yes/No .....

If No, How many day(s) do you have left? .....

State reason(s) for not fully utilizing your leave .....

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Staff Signature ..... Date .....

Comments by the Head of Department/Unit .....

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Name of the Dean/HOD/Unit .....

Signature of Dean/HOD/Unit ..... Date.....

Comments by the Establishment & Human Resources Officer.....

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Signature..... Date.....