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**KÖYCEĞİZ SAĞLIK HİZMETLERİ MESLEK YÜKSEKOKULU**

**MÜDÜRLÜĞÜNE**

Okulunuz \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ programı

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ numaralı öğrencisiyim. Öğrenci kaydımın silinmesi hususunda gereğini arz ederim.

Ad/Soyad

İmza

İletişim Bilgileri:

Cep No:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

e-posta :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Adres :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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