 Khyber Medical University

Peshawar

**APPLICATION FORM FOR RETOTALLING**

|  |  |  |  |
| --- | --- | --- | --- |
| **Roll No** | **Year of Examination** | **Annual / Supply** | **Date of Declaration of Result** |

Name of Candidate:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father’s Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Examination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Center of Examination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Subject(s) in which retotalling to be desired:**

|  |  |  |
| --- | --- | --- |
| **Subject** | **Marks Obtained** | **Total Marks** |
|  |  |  |
|  |  |  |
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|  |  |  |
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Fee of Rs.\_\_\_\_\_\_\_\_\_\_\_ Deposited vide\_\_\_\_\_\_\_\_\_\_\_\_ Receipt/DD no.\_\_\_\_\_\_\_\_\_\_\_\_\_

Dated\_\_\_\_\_\_\_\_\_\_\_\_\_in the name of Treasurer, Khyber Medical University

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| --- |
| **Justification (Optional)** |

**NOTE: Retotalling is allowed within a period of Fifteen (15) days after the declaration of the result.**