

**NAME OF THE COLLEGE-EXAMINATION CENTRE**

**(Affiliated to Odisha University of Health Sciences, Bhubaneswar)**

No.

Date\_\_\_\_\_

To,

The Controller of Examination,

Odisha University of Health Sciences,

Bhubaneswar.

**ATTENDANCE SHEET OF THE SUPERINTENDENT, DEPUTY SUPERINTENDENT, INVIGILATORS &  
STAFF ENGAGED FOR THE EXAMINATION DUTY**

**(TO BE PREPARED SEPARATELY FOR EACH SESSION ON EACH DAY)**

Name of the Centre \_\_\_\_\_

Course:

Day:

Date\_\_\_\_\_

Session \_\_\_\_\_

Sl No	Name	Designation	Nature of Duty	Teacher Regn no. if app.	Signature

Date:

Signature of the Superintendent

With Stamp