

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

Session

Session

Date:

Signature of the Superintendent

With Stamp