

SUPERINTENDÊNCIA DA ESCOLA DE SAÚDE DE GOIÁS

Curso

Curso: Edital nº:

E-mail: Telefone: ( )

Nome: CPF:

**TERMO DE DESISTÊNCIA**

Nº\_\_\_\_\_\_\_\_\_

**DESCRIÇÃO DA JUSTIFICATIVA**

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­­­­­­­­Assinatura e Data

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Ciência do Gestor /assinatura e carimbo

Anápolis, 17 de outubro de 2017.