

## WAIVER REQUEST FORM

The purpose of this form is to get detailed information about the applicant. Requests will be assessed on a case-by-case basis. The waiver request will normally be answered within one to two weeks of the application date. Save your entries and send the completed form to the Managing Editor to forward it to the Editorial office of Scientific Archives of Dental Sciences (SAODS) (ISSN: 2642-1623).

## NOTE:

All the below fields MUST be completed if not your application will not be considered. If question is not applicable, enter n/a. For additional co authors and/or the official statement from the University, please send it by email to the Managing Editor.

ACCEPTED MANUSCRIPT TITLE:

APPLICANT DETAILS		
Article Title:		
Affiliation:		
Full Name:		
Position:		
CO-AUTHORS (INCLUDE ALL YOUR CO-AUTHORS)		
Article Title:		
Affiliation:		
Full Name:		
Position:		
Article Title:		
Affiliation:		
Full Name:		
Position:		
CONTACT		
E-mail:		
Web link:		
Telephone:		
Country/State:		
Have you already collaborated with SAODS as an author/editor/reviewer?	Yes	No

If you cannot make the payment due to lack of funding from the University/Centre/Laboratory you are affiliated with, provide us with an official statement.

## NOTE:

All fields MUST be completed if not your application will not be considered. If question is not applicable, enter n/a. For additional co authors and/or the official statement from the University, please send it by email to the Managing Editor.