Consent of the Hospital abroad with the practice

Full name of the student: ……..……

E-mail: .....…….....

Practice in subject: ……..……..……

Dates of the practice: ……..…….....

Address of the Hospital abroad:

……..……..
……
……
……
.....……...
.....……...

Address of the "home" Faculty:

Charles University
Faculty of Medicine in Hradec Králové
Šimkova 870
500 03 Hradec Králové
CZECH REPUBLIC

Signed on behalf of the particular dept. of the above specified Hospital by:

Printed Name: ……..…..……

Position: ……

Signature: ……..…..

Date: ……..……

E-mail contact: ……

(Official seal or stamp)

Signed on behalf of the particular dept. of our University Hospital:

Printed Name: ……..…..…….……

Position: ……..…….

Signature: ……..…….……..

Date: ……..…..……..……

E-mail contact: ……

(Official seal or stamp)

Printed Name of the Tutor:

……..……..

E-mail contact: ……..…….