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
Šímkova 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: ..............................