SEMMELWEIS UNIVERSITY
Faculty of Dentistry
Education and Further Training Office

Declaration of completion of practical course

I. Trainee:

Full name:

.....

place of birth, date of birth:

.....

mother's maiden name:

.....

medical stamp:

.....

II. Information on training:

Specialization:

.....

Duration of specialization:

from ..... - to ....

Suspension of training:

period of suspension:

.....

reason for suspension:

.....

Consideration by law:

Working activity:

.....

Place of activity:

.....

Correspondence address: H-1085 Budapest, Üllői út 26.
Registered Office: H-1088 Budapest, Szentkirályi u. 47.
Phone: +36 1 266-7006
e-mail: szkepz@dent.semmelweis-univ.hu
Opening hours: 9:00- 11:00, Thursday

Period of activity:

.....

III. Information on the completion of practical course:

Place of practical course :

.....

.....

Supervising tutor's

name:

.....

time completed at an accredited place of training:

from .....to ....

weekly ..... hours.

Date: ..... ,..... day ..... month ..... year.

.....

.....

signature of head of dentistry (employer)
P.H.

signature of supervising tutor
P.H.

.....

signature of candidate

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