

**DECLARATION OF ACCEPTANCE BY AN ACCREDITED PLACE ON THE  
ACCOMPLISHMENT OF PRACTICAL COURSE**

**Specialization:** .....

**Trainee's**

Name: .....

place of birth, date of birth (dd/mm/yyyy): .....

mother's maiden name: .....

medical stamp: .....

*Filled out by the head of healthcare provider:*

**Healthcare provider's:**

name: .....

address: .....

phone: .....

accreditation expiry date: .....

**Supervising tutor's**

name: .....

medical stamp: .....

qualification(s): .....

date of qualification(s): .....

I hereby guarantee the preparation of the trainee for the period of **36 months** with the direct supervision of the tutor conducting the practical training, (as an external training place: minimum **36 working hours weekly**, pursuing medical activity in the framework of an employment relationship) I ensure that the supervisor of the practitioner (tutor) directly managing the practical training at least in 30 hours a week. Further, I declare that I maintain cooperation both with the Education and Further Training Office and the university professor (mentor). Also, I ensure cooperation with the Trainee. This declaration is not an obligation for Semmelweis University Faculty of Dentistry, it only indicates the intention of the receiving healthcare provider to the training of the specialist. After the healthcare provider's statement of intent, Dean of the Faculty decides whether the candidates can enter the training.

Date: .....

P.h.

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Signature of the health service provider's  
director