

**DECLARATION OF ACCEPTANCE OF WORK  
EMPLOYMENT AT SEMMELWEIS UNIVERSITY**

\*  
Undersigned .....

Place and Date of Birth: .....

Mother's name: .....

Address:.....

**\*\*I ACCEPT**

**\*\*I DO NOT ACCEPT**

**the work employment at Semmelweis University Faculty of Dentistry.**

Date: ..... 201.... .....

.....  
signature

**The decision about the appeal must be communicated to the applicant within 48 hours. Failure to issue the statement will evoke a termination of rights.**

\* Please fill out the form with capitals

\*\* Please underline