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: ..... 20..... .....

.....
signature

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

* Please fill out the form with capitals

** Please underline