LETTER OF ACCEPTANCE

FOR OBLIGATORY INTERNSHIP IN FAMILY MEDICINE
AS PART OF THE STUDENTS' SIXTH YEAR'S CURRICULUM

Student's Name: .....

Date and place of birth: .....

The above student of SEMMELWEIS University, Budapest is authorized to perform his/her clinical rotation in our department according to the required rotation program.

Duration of practice: from ..... until .....

.....
Date and Place

.....
Name of Hospital/Clinic

.....
Signature of Professor in charge/
Head of Department

.....
Name in capital letters

.....
Name in capital letters

GENERAL INFORMATION FOR AUTHORIZATION OF A DEPARTMENT FOR THE 6-YEAR'S CLINICAL ROTATIONS

Information about the hospital

Name of the hospital: .....

.....

Address and website: .....

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Population receiving health care service: .....

Number of inpatients and outpatients cared for, per year: .....

Departments under hospital supervision: .....

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Clinical training programs (if present, affiliation to university): .....

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Specific information regarding the desired department

Name of the Department: .....

Sub-divisions (if present): .....

Specialties: .....

Outpatient-ward information: .....

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Number of beds: .....

Contact information: .....

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