

# LETTER OF ACCEPTANCE

FOR OBLIGATORY INTERNSHIP IN \_\_\_\_\_  
AS PART OF THE STUDENTS'S 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*