

LETTER OF ACCEPTANCE

1 week/30 hrs of district adult consultation practice

Name of the student:.....

Period of practice:.....

Name of the GP:

Address of the GP:

Phone number of the GP:

E-mail address of the GP:

The above-named 6th-year student is accepted to perform his/her compulsory practice at my surgery for a period of one week (30 hours).

Date:.....

Signature:.....

Stamp