University of Szeged, Albert Szent-Györgyi Medical School
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LETTER OF ACCEPTANCE

1week/30 hrs of child district practice

Name of the student:……..…….....

Period of practice:……

Name of pediatrician: …….…….

Address of pediatric surgery: …….…….…….

Phone number of pediatrician: …….……..……..

E-mail address of pediatrician: ……

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

Date:……..

Signature:…… Stamp