UNIVERSITY OF DEBRECEN
FACULTY OF MEDICINE
DEAN'S OFFICE
REGISTRAR'S OFFICE

F. 1069/1.C

LETTER OF ACCEPTANCE FOR MID-YEAR BLOCK PRACTICE

ACCORDING TO THE CURRICULUM OF THE UNIVERSITY OF DEBRECEN, FACULTY OF MEDICINE, IT IS A REQUIREMENT TO COMPLETE 2 X 2 WEEKS PRACTICE IN THE 1ST AND 2ND SEMESTER OF THE 4TH AND 5TH YEAR OF THE FOLLOWING SUBJECTS:

4th year	1st semester	2 weeks Internal Medicine (Cardiology, Angiology)
		2 weeks Surgery / Small Surgery or 1 week Obstetrics & Gynecology and 1 week freely chosen
	2nd semester	2 weeks Internal Medicine (Endocrinology, Nephrology)
		2 weeks Surgery / Small Surgery or 1 week Obstetrics & Gynecology and 1 week freely chosen
5th year	1st semester	2 weeks Internal Medicine (Gastroenterology)
		2 weeks Pediatrics or 1 week Neurology and 1 week freely chosen
	2nd semester	2 weeks Internal Medicine (Hematology and Haemostaseology)
		2 weeks Pediatrics or 1 week Neurology and 1 week freely chosen

STUDENTS ARE ALLOWED TO DO PART OF THEIR MID-YEAR BLOCK PRACTICE OUTSIDE OF HUNGARY, WHICH MUST BE APPROVED PREVIOUSLY BY OUR UNIVERSITY.

THE PRESENT VERIFICATION FORM MUST BE SIGNED BY THE HEAD OF THE DEPARTMENT OF THE HOSPITAL, WHERE THE STUDENT IS GOING TO DO HIS/HER PRACTICE AND THE FORM MUST BE SENT/FAXED BACK TO THE UNIVERSITY OF DEBRECEN, ON THE ABOVE ADDRESS TWO WEEKS BEFORE STARTING THE PRACTICE.
The costs of practices outside of UD must be covered by the student(s).

Pál Pap M.Sc., Ph.D.
Registrar
on behalf of the
Faculty of Medicine

Applicant must complete this section:
I, _____, apply to do my _____ practice in the hospital named below.

_____
Signature of student

Certification of the accepting teaching hospital:

This is to certify that the above named student is accepted to our institute to complete his /her clinical practice and will have the possibility to fulfill the requirements of the practice, described in the attached practicum booklet.

Name: _____

Signature: _____

Title: _____

Affix Institutional Seal Here.

Name of University Hospital: _____

_____

Department: _____

_____

City: _____ Country: _____

Starting on: _____ till _____

Number of weeks: _____

Date of Signature: _____

Phone/fax: _____