THE PAPER OF ACCEPTATION

The 6-months Working Practice (*The Internship – 26 Weeks*) of the students of the Master Degree of Pharmacy of the Faculty of Pharmacy at the University of Veterinary and Pharmaceutical Sciences Brno

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All the blank spaces must be filled in legibly (in block letters).

I agree that the student of the Faculty of Pharmacy of the University of Veterinary and Pharmaceutical Sciences Brno mentioned below will perform (part of) his/her 6-month Working Practice in the pharmacy in the stated term:

Name and surname of the student: ……

Name of the pharmacy:

……

Address of the pharmacy:

……

Telephone: …… **Fax**: ……

E-mail: ……

Working practice from: …… **to**: ……

Owner of the pharmacy (name, address):

……

Pharmacy's employee (advisor) in charge of the student's practice:

……

Date: Signature of the advisor

Official stamp