**PRACTICAL CLINICAL TRAINING ABROAD- APPLICATION FORM**

**STUDENT INFORMATION**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Surname | | |  | |  | | | | |
| First and middle name | | |  | |  | | | | |
| Year of study\* |  | Program | MD Advanced / 6MD | Academic year |  |  | Clinical group: | |  |
| Scheduled time of elective: | |  |
| Mean grade (GPA) obtained in the first 4 semesters for students of MD Advanced program and the first 8 semesters for students of 6 MD program | | | | | | …………………… | | ……………………………………….  (administrative coordinator’s signature and stamp) | |

\*At the time of completing practical clinical training

**CLINICAL TRAINING INFORMATION**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Course** |  | | | | |  |
| Start date (dd/mm/yyyy) |  | End date (dd/mm/yyyy) | |  | | |
| No. of weeks: | **6** | No. of hours: | **180** | ECTS: | **12** | |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Hospital Information** | | |  | | | | |
| Name of the hospital | |  |  | | | | |
| Affiliation with University | |  |  | | | | |
| City | |  |  | Country | |  | |
| Street | |  |  | Number | |  | |
| Phone number | |  |  | | | | |
| **Supervisor contact information** | | |  | | | | |
| Name and Title |  | |  | | | | |
| E-mail |  | |  | | Phone No. | |  |

**VERIFICATION** (all fields mandatory)

|  |  |  |
| --- | --- | --- |
| I hereby certify that all the above information is correct to the best of my knowledge and that the student is accepted for the clinical training in compliance with the MUL’s requirements. (see: The Book of Student Vocational Placement Training – Practical Clinical Training) | | **Institution’s stamp/ID card** |
| **Supervisor’s Signature** | Date |  |

The student hereby declares to be responsible for Malpractice Insurance.

|  |
| --- |
| Student’s Signature: |

|  |  |
| --- | --- |
| The Dean’s Signature | Official Stamp |

**Instructions:**

**Please TYPE in all required information**. **Incomplete forms will NOT be recognized by the MUL.** Official stamp of the hosting institution is REQUIRED for the form to be recognized as an official document. Please do not use whiteout. Any corrections on the form should be verified with a stamp, date and initials.

**Please return the form to the MUL to get official Dean’s permission for practical clinical training until 30th June of the academic year preceding the clinical training.**

Contact information: Medical University of Lodz, Administrative Center for Studies in English, 1 Hallera Sq. 90-647 Lodz Poland; e-mail: [*deans.office@umed.lodz.pl*](mailto:deans.office@umed.lodz.pl)*;* phone no.: +48 42 272 50 57