LETTER OF ACCEPTANCE

4-week summer pharmacy practice

Name of student: .....

Name of pharmacy: .....

Address of pharmacy (country, city, street, house number): .....

.....

.....

The above-named ..... year pharmacy student is accepted to perform his/her compulsory practice at our pharmacy.

Period of practice (year, month, day – year, month, day): .....

Name of the head of pharmacy: .....

Name of the instructor pharmacist: .....

Accreditation number: .....

Date (year, month, day): .....

STAMP

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signature