

LETTER OF ACCEPTANCE

compulsory practice prior to the final examination

Name of student:

Name of pharmacy:

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

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.....

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