



POZNAN UNIVERSITY OF MEDICAL SCIENCES
CENTER FOR MEDICAL EDUCATION IN ENGLISH

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ELECTIVES REQUEST FORM

Name of the student:.....

Electives coordinator:.....

Departament:.....

Location:..... **Dates:**

from..... to.....

Length: weeks

I give my permission to above mentioned student to perform part of his/her clinical clerkship under my supervision.

- I hereby declare that I am PUMS' employee
- I hereby declare that I am not PUMS' employee

Date:.....

Signature of the electives coordinator

ATTENTION!

Electives request form must be delivered to the Dean's Office 14 days prior elective's start, otherwise elective will not be effective.