

*(photo)*

POZNAN UNIVERSITY OF MEDICAL SCIENCES

INTERNSHIPS/TRAINING APPLICATION FORM

academic year: 201......./201.........

*student’s personal data*

|  |  |  |  |
| --- | --- | --- | --- |
| Family name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Permanent address: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| First name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| Field and year of study: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Telephone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Sex: | male/female\* | e-mail: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Date of birth: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Mailing address:  *(if different from above)* | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Nationality: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Telephone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  | e-mail: |  |
| Person back home should be notified in emergency | | | |
| Family name: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Telephone: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| First name: |  | e-mail: |  |

*sending and receiving institutions*

|  |  |  |
| --- | --- | --- |
|  | *sending institution* | *receiving institution* |
| Name |  | poznan university of medical sciences |
| Full address |  | ul. fredry 10 |
| Zip code, city |  | 61-701 poznan |
| Faculty |  | Faculty of medicine 2 |
| Course |  |  |
| *Contact person* | | |
| Name |  | Bożena Raducha |
| Phone |  | +4861 854-60-36 |
| Fax |  | +4861 854-62-68 |
| e-mail |  | braducha@ump.edu.pl |

*language skills*

|  |  |  |  |
| --- | --- | --- | --- |
| Communication language(s) | Currently studying this language? | Sufficient knowledge to follow lectures/clinics? | Need some extra preparation? |
|  | Yes/No\* | Yes/No\* | Yes/No\* |
|  | Yes/No\* | Yes/No\* | Yes/No\* |
|  | Yes/No\* | Yes/No\* | Yes/No\* |

\* circle the proper answer

*accomodation*

|  |
| --- |
| Do you need accommodation? YES or NO |

*ELECTIVES period abroad*

|  |  |
| --- | --- |
| Beginning date: |  |
| Conclusion date: |  |
| Number of expected hours per day: |  |

*previous and current study*

|  |  |
| --- | --- |
| Subject area: | MEDICINE |
| Number of higher education study years prior to departure abroad: |  |
| Have you already studied abroad? | Yes/No\* |

\* circle the proper answer

|  |
| --- |
| **Suggested programme of the internships/training:** |
| **Expected knowledge**, **skills and competences to be acquired by the trainee at the end of the internships/training.**  … |

.......................................................

Signature of the Intern/Trainee