MEDICAL UNIVERSITY OF WARSAW

FACULTY OF MEDICINE

Medical University of Warsaw
Dean's Office of the Faculty of Medicine
ul. Żwirki i Wigury 61, 02-091 Warsaw

Warsaw, ...
(date)

Letter of Referral for the Student Clerkship

The Dean's Office of the Faculty of Medicine at the Medical University of Warsaw hereby refers

Mr./Ms. ……., a ……. year of study student of

the Medical Program (MD), to:

.....

.....
(Name of the institution / healthcare facility and address of the internship location)

for the purpose of completing the required student clerkship during the period

from …… to .....

.....
(signature and stamp of authorized person)

I consent to the transfer of my personal data, such as my name, surname, and form and field of study, to:

.....
(Name of the institution / healthcare facility)

in connection with my Student Clerkship.

Warsaw, ...
(date, first name, surname and signature of student)