LETTER OF ACCEPTANCE

2-month pharmacy practice

Name of the student:…………………………………………...

Name of the pharmacy:………………………………………………………………………...

Address of the pharmacy: ……………………………………………………………………...

The above-named ………………………(year) pharmacy student is accepted to perform his/her compulsory practice at our pharmacy for a period of two months.

Period of practice:……………………………………………………………………………...

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

Name of the pharmacist:………………………………………………………………………..

Accreditation number:………………………………………………………………………….

Date:………………………………………..

Signature:…………………………………… Stamp