

LETTER OF ACCEPTANCE

4-week summer 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 four weeks.

Period of practice:.....

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

Name of the pharmacist:.....

Accreditation number:.....

Date:.....

Signature:.....

Stamp