**Ministry of Health of the Czech Republic**

**Department of science and education**

**Division of medical professions and validation of qualifications**

**Palackého square 4**

**128 01 Prague 2**

**R E Q U E S T**

**(in accordance with the law no. 95/2004 Sb.)**

**for a professional traineeship or its part to be acknowledged and validated as a component of higher specialized education under postgraduate doctorate studies,**

**provided that it tallies to at least a half of week's worth of established working hours and its content and extent corresponds to the respective educational programme. Simultaneously the above mentioned study period has to be corroborated by a supervisor and the statutory medical institution, where its majority was effectuated.**

Field of specialized education and student's date of inclusion into the programme ............................................................................................................

Doctoral study programme, date of commencement
................................................................................................................................

**First name, surname, academic title**  ……………………………………….........................................
Maiden name ……………………………….......

Nationality …………....................................

**Date and place of birth**  ……………………………......

Contact address …………………………………………………………………………………...

Postcode ………………..............
Telephone ……………………....
E-mail...................................

Place of work……………………………………………… Department……..……………………………......

Position……………………………………………….

Professional traineeships (in chronological order):

establishment: department: since – until:

number of hours spent working as a doctor per week:

|  |  |  |  |
| --- | --- | --- | --- |

The aforesaid traineeship is documentable in the certificate of expertise.

Specialized internships (field of activity, place, date):

…………………………………………………………………………………………………...

*I hereby explicitly declare that I agree with the processing of personal data provided by me for the purposes of this request by the Ministry of Health. equally as with the possibility that my personal data may be provided to third parties in accordance with the relevant enactments of Act no. 101/2000 coll. about the protection of personal data and the alteration of certain laws, as amended.*

 ***I do declare that all the information provided in this application is correct, complete and based on truth.***

| ***First name and surname:***      | ***Signature:*** | ***Date:***      | ***Place:***      |
| --- | --- | --- | --- |

Confirmation of the supervisor that the said professional practice corresponds to the content and extent of the relevant educational programme (records of completed procedures to be found in the logbook) ………………………………………………………………………………………………………...

………………………………………………………………………………………………………...

 Date stamp name and signature

The approval and standpoint of the statutory body of the medical facility:

 Date stamp name and signature

**Supplements to the request:**

* a copy of the certificate of expertise/speciality index to substantiate a traineeship and/or a procedure
* a logbook (record of procedures executed during specialized education)
* a copy of an identity card (ID)
* a copy of a marriage certificate in case of a woman’s change of name