**Third Faculty of Medicine, Charles University**

**Postgraduate Doctorate Studies**

Name and surname: ...................................................................... Year: .......................

Programme: ................................................................................................................................

Address: .................................................................... Telephone: ….....................................

**REQUEST**

for ..............................................................................................................................................

Statement of grounds:

Date:

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Signature of student

|  |
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| Statement of the Supervisor:  ……………………………...  Date: signature |
| Statement of the Chairman of Doctoral Study Board :  ……………………………...  Date: signature |
| Statement of the Dean/Vicedean:  ……………………………...  Date: signature |