**Third Faculty of Medicine, Charles University**

**Postgraduate Doctorate Studies**

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

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

Address : .................................................................... Phone : ................................

**WITHDRAWAL FORM**

In accordance with clause 56 paragrapf 1, a) of Act No. 111/1998 Coll., on Higher Education Institutions and on Amendments to Other Acts (Act on Higher Education Institutions)1, as amended, I hereby declare that I am leaving studies at the Third Faculty of Medicine at Charles University.

Date: Signature of the student:

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