CLINICAL TRAINING FORM

NOVA Medical School|Faculdade de Ciências Médicas

Universidade NOVA de Lisboa

To the professor/lecturer/doctor responsible for the student's training:

Please complete the following information and give the original document, signed and stamped to the student. Thank you for your cooperation.

Name of student: _____

Training location: _____

_____

Name of Tutor responsible for training: _____

Name of subject: _____

_____

Head Professor of the subject: _____

Training period: from _____ to _____

Duration (total of hours): _____

Signature: _____ Date: _____

Institutional stamp: