**DECLARATION OF STAY**

Name of Student:

Course: MEDICINE

Sending Institution: NOVA Medical School|Faculdade de Ciências Médicas

Receiving Institution:

**ARRIVAL**

I certified that the student has been registered at the host university on

|  |  |  |
| --- | --- | --- |
| Day | Month | Year |
|  |  |  |

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*(Institutional Stamp and Signature)* Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_\_

**DEPARTURE**

I certified that the student has completed his/her study programme on

|  |  |  |
| --- | --- | --- |
| Day | Month | Year |
|  |  |  |

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*(Institutional Stamp and Signature)* Date: \_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_