APPLICATION FOR PRE-APPROVAL OF CLINICAL TRAINEESHIP - ABROAD

Student ID-Number:							

Last Name:	First Name(s):

Date of Birth		
day	month	year

Clinical Traineeship[1] from			to:		
day	month	year	day	month	year
Number of days worked:			Number of hours worked:		
Discipline/Specialisation:					

Hospital name:	
Hospital adress:	
University Clinic/Department:	Head of University Clinic/Department:
Inpatient ward: O YES O NO (Please tick the box!)	

Please have the following section completed by the teaching hospital or university clinic:
Confirmation that the institution is a university clinic or teaching hospital: (Please check the appropriate option!) O YES O NO Place, Date Signature and official stamp Head of University Clinic/Department/Medical Management

Please **do not** fill out this section. It will be completed by the Center for Medical Education at JKU:

Confirmation that this is a teaching hospital has been provided. O YES O NO

Date: ___________________________________

[1] Traineeship in accordance with the Austrian Medical Practitioners' Act § 49 Para. 4.