Warsaw, ..............................

First name and last name ………………………………………………………………………………...…………………..…..

Address of residence, city, postal code ................ ....... ......... ....... ................................. .. ............

Telephone number ........................................ email address: ................................................ .. ....... ... ...

Name of university ................................................................................................... .. .......... ....... ....

Faculty .................................................................................................................................

Department ................................................................................................................ ................

Year of study ...........................................................................................................................

**MANAGEMENT OF THE**

**"CHILDREN’S MEMORIAL HEALTH INSTITUTE"**

                                                                          Al. Dzieci Polskich 20, 04-730 Warsaw

I request your permission to take a student internship in ……………....................................................

 (*name of a Clinic/Institution)*

……………………………………………………………………………………………………………

from ……………………………. to ………………..…………..for…….……………. hours

                      .....................................

                                legible student signature