APPLICATION FORM FOR BASIC TREATMENT IN DENTAL MEDICINE SUMMER PRACTICE
2019

Basic Treatment in Dental Medicine summer practice (4 weeks)
on the **Faculty** 08 July-02 August
or **outside the Faculty** in July and August

Name, group number: _____

Address: _____

Chosen time: _____

Place of summer practice (name, address, phone number):

6720, Szeged, Tisza Lajos körút 64.

_____

Name of supervisor:

dr. Márk Fráter

_____

In case the summer practice is done outside the Faculty the submission of the Letter of Acceptance is mandatory.

_____

signature

Deadline for submission: 05 April, 2019

University of Szeged
Where knowledge and challenge meet
FACULTY OF DENTISTRY SZEGED, HUNGARY
Associate Professor Zoltán Lajos habil BARÁTH

H-6720 SZEGED, Tisza Lajos körút 64. Tel.: (00 36 62) 545-299, Fax: (00 36 62) 545-282 E-mail: stoma@stoma.szote.u-szeged.hu

LETTER OF ACCEPTANCE

4-week practice in basic treatment in dental medicine

Submission deadline: 05 April, 2019.

Name of the student:	
Period of practice (DD/MM/YYYY):	From: To:
Name of the hospital/clinic:	
Department:	
Address of the hospital/clinic:	
Accreditation number of the hospital/clinic:	
Contact person:	
Phone number:	
E-mail address:	

I declare that the above-named student of the University of Szeged is accepted to perform his/her compulsory basic treatment in dental medicine summer practice at our institution for a period of 4 weeks, furthermore, that the means of completing the tasks listed on page 2 of this form are provided and that he/she is entitled to complete them.
I declare that the clinic/hospital has an operating licence and based on the patients' data is competent of the training of dental students within the frame of the summer practice.

Date:	
Signature:	

Institution seal/stamp

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Basic treatment in dental medicine summer practice
4 weeks

Compulsory tasks to be completed during the practice spent at a foreign institution

- One piece of upper or lower total removable denture, or fixed prothesis
- One piece of partial removable denture or one piece of post and core with crown or one piece of short bridge
- Four fillings, one inlay, two root canal preparations and obturations
- Recording of periodontal status of four patients, completion of treatment planning
- Completion of non-surgical periodontal treatments

Faculty of Dentistry

BASIC TREATMENT IN DENTAL MEDICINE PRACTICE EVALUATION SHEET
4 weeks

This is to certify that Mr./Ms. .....
(born on (DD/MM/YYYY) ..... in (city/country) ...../.....)
completed every one of the following tasks as a part of an basic treatment in dental medicine practical training at our institution:

Compulsory tasks to be completed	Stamp and signature of the supervisor
1. One piece of upper or lower total removable denture, or fixed prothesis	
2. One piece of partial removable denture or one piece of post and core with crown or one piece of short bridge	
3. Four fillings, one inlay, two root canal preparations and obturations	
4. Recording of periodontal status of four patients, completion of treatment planning	
5. Completion of non-surgical periodontal treatments	

The completion of each task must be verified individually with the stamp and the signature of the student's supervisor at the institution.

Period of practice: From (DD/MM/YYYY) ..... to (DD/MM/YYYY) .....
Name of the clinic/hospital in capital letters: .....
.....
Address of the hospital/clinic in capital letters: Country: ..... City:.....
.....
.....
Department: .....
Accreditations of the hospital/clinic: .....
.....
.....
Name of the supervisor in capital letters: .....
Phone number: .....
E-mail address: .....@.....
Evaluation of the student: .....
.....
.....
Date: ..... **Signature and stamp** .....