amU Faculté de pharmacie Aix Marseille Université

Academic Year 20….. / 20…..

REQUEST FOR EXEMPTION FOR AN OFFICIAL PHARMACY INTERNSHIP OUTSIDE THE DISTRICT

LAST NAME: …… FIRST NAME: …….

Student in the ……. year at ……..

Personal Address: ……..

Phone: …… E-mail: …….

REQUESTS AUTHORIZATION TO COMPLETE:

☐ Introductory Pharmacy Internship (2nd year)

☐ DFG SP3 Application Internship (3rd year)

☐ DFA SP1 Application Internship (4th year)

☐ Professional Practice Internship (6th year)

☐ Other

With (name of supervising pharmacist): ……
Pharmacy Address: ……..
From …… to ……..

Is this pharmacist a registered internship supervisor? ☐ Yes ☐ No
REASON FOR REQUEST (attach cover letter):
In ……, on ……. / ……. / ……. Student's Signature:

Approval of the Dean of the Faculty of Pharmacy in the District Where the Student Wishes to Complete Their Internship. **APPROVED** **NOT APPROVED** In ……, on ……. / ……. / ……. Dean's Signature,	**Approval of the Pharmacy Internship Coordinator of the Faculty of Pharmacy at Aix-Marseille University.** **APPROVED** **NOT APPROVED** Marseille, on ……. / ……. / ……. Dean's Signature, **Approval of the Dean of the Faculty of Pharmacy at Aix-Marseille University.** **APPROVED** **NOT APPROVED** Marseille, on ……. / ……. / ……. Dean's Signature,