**Letter of Acceptance for State Exam Practice**

**Name of Student:**

**-----------------------------------------------------------------------------------------------------------------**

**Name of Pharmacy, Address of Pharmacy, *email address*:**

**-----------------------------------------------------------------------------------------------------------------**

**Name of Pharmacist for Education:**

**Type of the State Exam Practice:**

* State exam practice I. Pharmacy dispensing (120 hours)
* State exam practice I. Prescription pharmacy (120 hours) **or** Institutional Pharmacy or Galenic laboratory (120 hours) *Please, choose only one of them (prescription or institutional) and mark it with an underline.*

2 months: July 15 – August 11, 2024; August 12 – September 13, 2024.

**Date:-----------------------------------------------------------------------------**

**Signature of Pharmacist:-----------------------------------------------------------------------**

**Stamp**