



To Whom It May Concern

I, the undersigned, _____, born in _____
on _____, currently enrolled in the ____ year of the Single Cycle Master's
Degree Program in Medicine and Surgery at the University of Rome "Tor Vergata", Italy ,
student ID number _____,

REQUEST AUTHORIZATION

to carry out a voluntary internship period at the department of

of the _____

under the supervision of Prof./Dr. _____

Rome, // _____

Student's Signature

Stamp and Signature of the Responsible Supervisor

Stamp and Signature of the Program Director of the Degree Course in Medicine and Surgery
