Attachment no. 8
to the regulation no. 65/XV R/2013
of the Rector of Wroclaw Medical University
of September 16th 2013

……
Date of the Request

……

Applicant's Name and Surname

……

Index Number

……

Year of Studies, Major, Level* and Form** of Studies

……

Address for Correspondence

……

Telephone No., E-mail Address

Dean of the Faculty…….
of Wroclaw Medical University

Request
for granting consent to change the faculty

Kindly grant the consent to change the faculty from:

.....
faculty, major
.....
level*, form of studies**
.....
year, semester

to:

.....
faculty, major
……
level*, form of studies**
……..**.....**
year, semester

Reasons:

.....
.....

Attachments:
a) Transcript of records, GPA and obtained number of ECTS points
b) ……
c) ……

_____
(Date and Applicant's Signature)

The Dean's Decision

.....
.....

_____
(Date and Dean's Signature

* Level of Studies: BA, MA, Uniform MA Studies
** Form of Studies: Full-Time, Part-Time