Jan Kochanowski University of Kielce
Faculty of Medicine

Kielce …… 20……

……..……..……
(first name and surname)

……...……..…
(year, field of study),

full-time studies, long-cycle Master's degree programme)

……..……
(Student ID number)

……..……
(contact info: telephone no., email)

THE DEAN OF THE FACULTY OF MEDICINE

……..…….

(firdt name and surname)

APPLICATION FORM

for the consent to be referred to the repetition of a semester/year of studies*

I kindly request to be referred to the repetition of the …… semester/year of studies* during the academic year of 20…..…/20…… due to not having earned credit from the following courses:

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.....

Yours sincerely,

.....
(student's signature)

* delete as appropriate

Opinion of the Director of the Institute of Medicine .....

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(dtate and signature)