**APPLICATION OF COLLABORATING INSTITUTIONS/DENTAL PRACTICES AND MENTORS**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name and surname) am applying to be a mentor of the student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (name and surname), for supervising his/her professional practice outside the School of Dental Medicine, and for rating his/her achievement during his/her final (12 th) semester of integrated graduate and postgraduate study of dental medicine in the academic year 2023/24,

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Place and Date Signature

**To be filled in by the mentor; employee of Health CENTER**

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| HEALTH CENTER |
| HEALTH CLINIC: |  |
| BRANCH OF THE HEALTH CENTER: |  |
| ADDRESS |  |
| OIB: |  |
| AUTHORIZED PERSON FOR REPRESENTATION: |  |
| PHONE NUMBER: |  |
| MOBILE PHONE NUMBER: |  |
| E-MAIL ADDRESS: |  |
| YEARS OF INTERNSHIP OF THE MENTOR: |  |
| **Filled in by the mentor; dental office in concession, private dental practice** |
| NAME OF DENTAL OFFICE: |  |
| ADDRESS: |  |
| OIB: |  |
| AUTHORIZED PERSON FOR REPRESENTATION  |  |
| PHONE NUMBER: |  |
| MOBILE PHONE NUMBER: |  |
| E-MAIL ADDRESS: |  |
| MENTOR: |  |
| YEARS OF INTERNSHIP OF THE MENTOR : |  |

**Filled in by the studentt :** e-mail address of the student\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_