



TRAINING AGREEMENT FOR FINAL-YEAR MEDICAL ELECTIVE/SHORT TERM TRAINEESHIP *under the supervision of experienced medical staff*

ACADEMIC YEAR 20__/20__

I. PERSONAL DETAILS OF THE STUDENT

Name of the student:		
Date of birth:		Place of birth:
Address:		
Country		
E-mail:		

II. SENDING INSTITUTION

Sending Institution:		
Address:		
Country:		
Coordinator:		
E-mail:		

III. RECEIVING INSTITUTION

Host organisation:	University of Cologne, Faculty of Medicine	
Address:	University of Cologne, Faculty of Medicine ZIB Med / Center for International Relations Joseph-Stelzmann-Str. 20 50931 Cologne	
Country:	Germany	
Incomings Coordinator:	Andrea Kurze	
E-mail:	andrea.kurze@uk-koeln.de	

IV. DETAILS OF THE PROPOSED CLINICAL TRAINING PROGRAMME AT THE RECEIVING INSTITUTION

Departments and duration: e.g.: 4 weeks Surgery		
Traineeship Period:	From:	Till:

IV. COMMITMENT OF THE THREE PARTIES

THE STUDENT

Date:

Student's signature:

THE SENDING INSTITUTION

We confirm that this proposed training programme is approved.

Date:

Coordinator's signature:

UNIVERSITY OF COLOGNE

We confirm that this proposed training agreement is approved.

Date:

Coordinator's signature: