



Republic of Türkiye (T.C.)
UNIVERSITY OF HEALTH SCIENCES
ÇOBANBEY FACULTY OF MEDICINE



Abroad Education Declaration Document

Application Date	
STUDENT INFORMATION*	
Student ID No	
Full Name	
Class /Year	
E-mail Address	
Phone Number	
Subject of the Request	
Supporting Institution/ Organization for the Education Process (If applicable, please specify)	
Student Signature	
INFORMATION OF THE APPLIED UNIVERSITY / CLINIC**	
University / Clinic Name	
Country	
University QS Ranking	
E-mail Address	
Phone Number	
INFORMATION OF THE APPLIED COURSE /INSTRUCTOR***	
Course / Program Name	
Course Dates (Day/Mounth/Year)	
Weekly Course Hours	
Course ECTS	
Practical Course Content	
Grade (Out of 100)	
E-mail Address	
Phone Number	
Instructor /Coordinator Name- Surname / Title- Signature	
Other (If any, please specify)	
EVALUATION****	
Result	
Explanation	

*This section will be filled out by the student.

** This section will be filled out by the applied university.

*** This section will be filled out by the instructor /coordinator at the applied university.

**** This section will be filled out by the University of Health Sciences.

APPROVAL