**AUTHORIZATION FORM FOR**

**INDIVIDUAL ELECTIVE TEACHING ACTIVITIES**

***Attendance at Care Departments or Research Laboratories***

The undersigned      , enrolled in the       year of the Degree Course in Medicine and Surgery for the Academic Year      , Student ID number

**REQUESTS**

authorization for the recognition of ECTS credits for Elective Educational Activities through the completion of a voluntary internship period at\*

Supervised by the tutor:

From       To

Educational objectives to be achieved:

Method of final assessment:

Student's signature

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

Tutor’s signature

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

*Catania,* ­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Noted and approved*

***The Degree Course Coordinator***

***\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

\* For the Departments, indicate the Hospital and the Unit; for the Laboratories, indicate the Department and Section.