CHARLES UNIVERSITY
Second Faculty of Medicine

Request for change of the form of study

Applicant	
Applicant's title, first name and last name:	
Date of birth:	
Doctoral study programme:	
Form of study (full-time/part-time):	
Start of study (year):	
Contact address:	

I hereby request a change in the form of study from full-time/part-time to full-time/part-time (cross out as needed).

Justification:	
Date and applicant's signature:	

Supervisor's statement:	
○ Agree ○ Disagree for the following reasons:	
Supervisor's titles, first name and last name:	
Supervisor's workplace (including address):	
Supervisor's contact details (phone, e-mail):	
Date and supervisor's signature:	

Statement of the subject area board:	
○ SAB agrees ○ SAB disagrees for the following reasons:	
SAB chairman's titles, first name and last name:	
Date and signature:	

Records of the Department for PhD Study:	
Delivered on:	
Forwarded to the SAB:	