Optional format Ex. No. 2

Date:

Postal address:
Fax:
e-mail address:
Telephone number (of the institution/ community pharmacy/company):
Web address of institution/community pharmacy/company (optional):

To the Dean Office;

I Hereby confirm that …….. (Student Number; Student Name) from the Faculty of Pharmacy of EMU, can commence his/her traineeship on …….. (dd/mm/yy); (planned no. of work days …….) at the named pharmacy above.

Sign