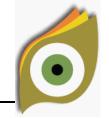
## **Hebrew University of Jerusalem**

Name and address of candidate:

## Veterinary Teaching Hospital בית החולים הווטרינרי P.O Box 12 Rehovot 76100. Tel:+972-(0)3-9688588, Fax: +972(0)3-9604079



## <u>Application Form – 3 months program</u>

First Name:	Surname:	I.D./Passport No:
Address:		
Phone:	Mobile:	Email:
Name and address of perso	n to contact in case of	emergency:
First Name:	Surname:	_
Address:		
Phone:	Mobile:	Email:
Relationship to the candidate	:	
Requested rotations		
☐ Equine Medicine ☐ Anesthesiology ☐ Oncology ☐ Cardiology ☐ Neurology ☐ Ophthalmology ☐ Radiology ☐ Exotic animals ☐ Dermatology  Requested starting date: ☐ Declaration:	re care and emergency  Requested	Dates
•	cover me in the event o	accination against rabies and have f accident or injury. I will not have
Signature:	Date: _	