



UNIVERSITATEA DE MEDICINĂ ȘI FARMACIE
„CAROL DAVILA“ DIN BUCUREȘTI



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**Endorsed by,
PhD Supervisor**

**APPROVED,
C.o.A on (date) : _____**

MISTER RECTOR,

The undersignedas PhD Student enrolled on (date)/...../....., form budget / tax, under the scientific coordination of Prof./Associate Prof.,in the University Doctoral Domain: Medicine, Dental Medicine, Pharmacy in UMF „Carol Davila” in Bucharest would kindly like to ask you to approve my **DEFINITVE WITHDRAWAL FROM THE UNIVERSITY DOCTORAL STUDIES.**

Date :

Signature,

PhD Student

.....

Phone no:

E-mail:

To The Rector of University for Medicine and Pharmacy „Carol Davila” in Bucharest