UNIVERSITA' DEGLI STUDI DI FIRENZE – I FIRENZE01

ERASMUS PROGRAM

EXTENSION OF STAY FORM

ACADEMIC YEAR 20__ / 20__

Name & Surname of Student: .... Registration ....

Home Institution:.. **Country** : ....

Host Institution: **I FIRENZE 01** **Country: ITALY**

Faculty of Medicine: Specific Degree for which you are studying:……………………………………

ORIGINAL PERIOD OF STAY: FROM______________________**- TO** ________________________________

NUMBER OF MONTHS: ____

NEW PERIOD OF STAY: FROM______________________**- TO** ________________________________

ADDITIONAL NUMBER OF MONTHS REQUESTED:____

HOME INSTITUTION

We confirm that this extension of stay is approved. **Date:**……………………….

Erasmus Institutional/Departmental Coordinator

Name (nome): ....

Stamp and Signature (firma): ....

HOST INSTITUTION

We confirm that this extension of stay is approved. **Date:**……………………….

Erasmus Institutional/Departmental Coordinator

Name (nome): ....

Stamp and Signature (firma): ....

Please note that this form must be first approved by the home institution