Training Application Form

ATTN.

Director of Osaka University Dental Hospital

The trainee named below requests to receive training here at Osaka University Hospital

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| Name of Trainee:  Nationality:  Institution, Job Title:  Training Period:  From(YY/MM/DD) To(YY/MM/DD)  Reason for application: |

(Compliance policy)

The trainee must comply with the regulations set by Osaka University Hospital and follow instructions given by the director.

(Suspension or cancellation of training)

If or when the trainee violates the above policies, the director carries the right to stop the training. (Compensation for loss and/or damages)

When the trainee causes any damage to the hospital, the trainee will be held responsible for the losses, even if it was caused by force majeure.

(Insurance)

The trainee must enroll in insurance to provide against any accidents during training. The cost for insurance will be paid by the trainee.

(Confidentiality)

Any confidential matters including patient information must not be handed down or given to any third parties during or after training.

Date(YY/MM/DD):

Applicant Name and Signature: