

Request for confirmation of degree

Instructions to educational institution: Please complete the form and kindly send it **directly in a sealed envelope** to the Danish Patient Safety Authority, Islands Brygge 67, 2300 Copenhagen S, Denmark.

Name of applicant:

Date of birth:

Degree:

Date of admission:

Date of graduation:

Is this school accredited or government approved? (x) Yes No

By whom?

Is this educational program accredited or government approved? (x) Yes No

By whom?

Name of educational institution:

Address:

Email:

Phone:

Date:

Print name:

Signature:

Stamp
and/or seal: