

Faculty of Medicine and Health Sciences
Postgraduate Diploma in CBT



MEMORANDUM OF UNDERSTANDING

Student Details

Name:

Contact details

Address:

e-mail :

telephone:

Position Held:

☐ **Funded by Employer** ☐ **Self-Funded** ☐ **Funded by Post-Registration Contract**

Workplace Manager Details

Name:

Contact details

Address:

e-mail:

telephone:

Position Held:

Student Signature.....Date

Manager Signature.....Date

If funded by post-registration contract please complete the details below:

Authorised Contract Signatory

Name..... (Please print)

Signature.....Date.....