



L-Università ta' Malta
Faculty of
Medicine & Surgery

Department
of Pharmacy

Application for change of Project

**PHARMACY PRACTICE PROJECT
PHR 3116/4120/5123**

Application for change of Project

Date: _____

Name of Student: _____ **Year:** _____

Generic Title: _____

Original Title of Project: _____

Reasons for change of title: _____

Title of Proposed Project: _____

Brief Description: _____

Protocol: _____

Remarks by Supervisor: _____

Materials/Equipment available: _____

Materials/Equipment required: _____

Project Supervisor

Signature of Project Supervisor

Comments Head of Department

Signature of Head
Department of Pharmacy