

International Clerkship Certificate

This is to certify, that

Mr / Mrs _____

born on the ____ / ____ / _____

participated for the duration of ____ weeks in the underneath described clerkship.

Hospital: _____

Department: _____

Town: _____

State: _____

Periode: _____

The student exercised the following clinical activities:

- taking the patient's history
- physical examination including measuring of blood pressure
- taking blood from a vein
- i.m & s.c. injections
- assisting in the following clinical activities:

The student completed the clerkship with / without success.

General Practitioners / Specialists for _____ are being trained at the above mentioned facility.

_____, __ / __ / _____
Place, Date

Name, signature and stamp of the head of department