# Summer Clerkship Certificate 1st Year

This is to certify that	Mr. / Ms	Name of student	
		rance of statem	
has attended 120 hou	rs of volunteer summer	clerkship under my st	upervision,
at			
	Name of hospital / Ins		
	Address (street, city, Z		
	Phone / Fax num		
between	Dates of attendance		
	Dates of attendance		
The clerkship program c	overs Nursing Practice.		
 Signature	Name and title	Institution_seal	Date
2161	Twine with the	individuon dear	Save
	For Office Use	Only	
Approved / Disapprov	ed		
Signature of School Official	Name	and title	Date

## Summer Clerkship Certificate 2<sup>nd</sup> Year

This is to certify that Mr	. / Ms		• • • • • • • • • • • • • • • • • • • •
,	,	Name of student	
has attended 90 hours of	volunteer summer o	elerkship under my su	pervision,
at	Name of hospital / Ins		
	Address (street, city, Z		
	Phone / Fax numb	per	
between			
	Dates of attendance		
T111.:	F	4:4)	
The clerkship program cover	s ramily fractice (outpo	anem).	
	NT 1 CO		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
Approved / Disapproved			
rippioveu/ Disappioveu			
6		1 (0)	
Signature of School Official	Name a	and title	Date

## Summer Clerkship Certificate 2<sup>nd</sup> Year

This is to certify that I	Mr / Ms		
11110 10 00 00101117 011010 1	1111	Name of student	
has attended 30 hours	of volunteer summer of	clerkship under my su	pervision,
at			
	Name of hospital / Ins	stitution	
•••••	Address (street, city, Z		• • • • • • • • • • • • • • • • • • • •
	radices (succe, eng, 2	ip code)	
	Phone / Fax num	ber	
1 .			
between			
	Dates of attendance		
The clerkship program cov	ors First Aid		
The electriship program cov	crs i irst iiu.		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
Ammorrad / Diagramorra	J		
Approved / Disapprove	a		
Signature of School Official	Name	and title	Date

# Summer Clerkship Certificate 3<sup>rd</sup> Year

This is to certify that	Mr. / Ms	Name of student	•••••
has attended 120 hour	rs of volunteer summer	clerkship under my st	upervision,
at	Name of hospital / Ins		
	1 ,		
	Address (street, city, Z		
	riddress (street, city, 2	ip code)	
	Dlama / Fara march		
	Phone / Fax num	ber	
between			
	Dates of attendance		
The clerkship program co	overs Internal Medicine.		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
Approved / Disapprove	ed		
Signature of School Official	Name	and title	Date

# Summer Clerkship Certificate 4<sup>th</sup> Year

	34 /34		
This is to certify that	Mr. / Ms	Name of student	•••••
has attended 60 hours	nded 60 hours of volunteer summer clerkship under my supervision,		
at			
	Name of hospital / Ins	titution	
	Address (street, city, Z	ip code)	
	Phone / Fax numl		
between			
	Dates of attendance		
The clerkship program co	overs Intensive Care.		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
Approved / Disapprove	ed		
Signature of School Official	Name	and title	Date

# Summer Clerkship Certificate 4<sup>th</sup> Year

mir recorded as	л / Ъл		
This is to certify that M	1r. / IVIS	Name of student	
has attended 60 hours o	of volunteer summer o	clerkship under my su	pervision,
at			
	Name of hospital / Ins		
	Address (street, city, Z		
	Phone / Fax num		
between			
	Dates of attendance		
The clerkship program cove	ans Dadiatnias		
The Cierkship program cove	ers reautites.		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
		•	
Approved / Disapproved	[		
11 , 11			
Signature of School Official	Name	and title	Date

# Summer Clerkship Certificate 5<sup>th</sup> Year

This is to certify that	Mr. / Ms	Name of student	•••••
has attended 60 hours	s of volunteer summer o	elerkship under my su	pervision,
at	Name of hospital / Ins		••••••
	Address (street, city, Z		
	Phone / Fax numb		
between	Dates of attendance		
The clerkship program c	overs Surgery.		
Signature	Name and title	Institution seal	Date
U			
	For Office Use	Only	
Approved / Disapprov	ed		
Signature of School Official	Name :	and title	 Date

# Summer Clerkship Certificate 5<sup>th</sup> Year

This is to certify that	Mr. / Ms	Name of student	•••••
has attended 60 hours	s of volunteer summer o	clerkship under my su	pervision,
at	Name of hospital / Ins		
	Address (street, city, Z		
	Phone / Fax numl		
between	Dates of attendance		
The clerkship program c	overs OB/GYN.		
Signature	Name and title	Institution seal	 Date
Signature	realite and title	institutori seai	Date
	For Office Use	Only	
Approved/Disapprov	ed		
Signature of School Official	Name	and title	Date