Summer Clerkship Certificate 2nd Year

This is to certify that M	ſr. / Ms	Name of student	
has attended 30 hours of	summer clerkship unde	er my supervision,	
at	Name of hospital / Ins		
	Address (street, city, Z		
	Phone / Fax numl	ber	
between	Dates of attendance		
The clerkship program cov	ers Emergency Medicine.		
		•	
		_	
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
	202 022200 000	y	
Approved / Disapproved	1		
Signature of School Official	Name	and title	Date

Summer Clerkship Certificate 2nd Year

This is to certify that M	Ir. / Ms	Name of student	
has attended 60 hours of	summer clerkship unde	er my supervision,	
at	Name of hospital / Ins		
	Address (street, city, Z		
	Phone / Fax numl		
between	Dates of attendance		
The clerkship program cove	ers Outpatient Care Praci	tice.	
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
Approved / Disapproved	I		
Signature of School Official	Name	and title	Date

Summer Clerkship Certificate 3rd Year

This is to certify that	Mr. / Ms	Name of student	
has attended 120 hours of summer clerkship under my supervision,			
at	Name of hospital / Ins		
	Address (street, city, Z		
	Phone / Fax numb		
between	Dates of attendance		
The clerkship program co	vers Internal Medicine.		
Signature	Name and title	Institution seal	Date
For Office Use Only Approved / Disapproved			
Signature of School Official	Name a	and title	Date

Summer Clerkship Certificate 4th Year

This is to certify that Mr.,		Name of student	
has attended 60 hours of sun	nmer clerkship under r	ny supervision,	
at	Name of hospital / Institu		
	Address (street, city, Zip		
	Phone / Fax number		
between	ates of attendance		
The clerkship program covers Intensive Care.			
Signature	Name and title	Institution seal	Date
For Office Use Only Approved / Disapproved Signature of School Official Name and title Date			

Summer Clerkship Certificate 4th Year

This is to certify that	Mr. / Ms	Name of student	
has attended 60 hours of summer clerkship under my supervision,			
at	Name of hospital / Ins		
	Address (street, city, Zi		
	Phone / Fax numb		
between	Dates of attendance		
The clerkship program c	overs Pediatrics.		
Signature	Name and title	Institution seal	Date
Approved / Disapprov		Only and title	Date

Summer Clerkship Certificate 5th Year

This is to certify that M	r. / Ms	Name of student	
has attended 60 hours of s	ummer clerkship unde	r my supervision,	
at	Name of hospital / Ins		
	Address (street, city, Zi	ip code)	
	Phone / Fax numb	er	
The clerkship program cove	Dates of attendance		
Signature	Name and title	- Institution seal	Date
For Office Use Only Approved/Disapproved			
Signature of School Official	Name a	and title	Date

Summer Clerkship Certificate 5th Year

	/		
This is to certify that	Mr. / Ms	Name of student	
has attended 60 hours	of summer clerkship unde	er my supervision,	
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
	For Office Use	Only	
	Tor Office Ose	Olly	
Approved / Disapprov	red		
Signature of School Officia	Name	and title	Date