### Summer Professional Clerkship Certificate 1<sup>st</sup> Year European Program Academic Year 2023/2024

This is to certify that Mr.,	/ Ms		
		Name of student	
has attended 120 hours of pr	ofessional summer cl	erkship under my super	rvision,
at	Name of hospital / Inst		
	Name of hospital / hist	itution	
	Address (street, city, Zi		
	Phone / Fax numb	er	
between			
Da	ites of attendance		
The clerkship program covers	Basic Patient Care.		
Signature	Name and title	Institution seal	Date
	For Office Use (	Only	
A			
Approved/Disapproved			
Signature of School Official	Name a	nd title	Date

#### Summer Professional Clerkship Certificate 2<sup>nd</sup> Year European Program

### Academic Year 2023/2024

To: The Office of the Dean The Medical University of Silesia in Katowice, POLAND This is to certify that Mr. / Ms. ..... Name of student has attended 90 hours of professional summer clerkship under my supervision, Name of hospital / Institution Address (street, city, Zip code) Phone / Fax number between ..... Dates of attendance The clerkship program covers Basic Health Care – Family Medicine. Name and title Signature Institution seal Date For Office Use Only Approved / Disapproved

Name and title

Date

Signature of School Official

# Summer Professional Clerkship Certificate 2<sup>nd</sup> Year European Program Academic Year 2023/2024

### The Office of the Dean

The Medical University of Silesia in Katowice, POLAND

To:

This is to certify that Mr.	/ Ms		
		Name of student	
has attended 30 hours of pr	ofessional summer cle	rkship under my super	vision,
at	Name of hospital / Inst		••••••
	Address (street, city, Zi		
	Phone / Fax numb	er	
between			
	Dates of attendance		
The clerkship program covers	s Basic Health Care – F	irst Aid.	
2 00 p. 02 00 + 0	2	<del></del>	
Ciamahana	Name and title	Institution seal	Data
Signature	Name and title	institution sear	Date
	For Office Use	Only	
Approved / Disapproved			
ripproved, Disapproved			
Signature of School Official	Name a	nd title	Date

#### Summer Professional Clerkship Certificate 3<sup>rd</sup> Year European Program

### Academic Year 2023/2024

To: The Office of the Dean The Medical University of Silesia in Katowice, POLAND This is to certify that Mr. / Ms. ..... Name of student has attended 120 hours of summer clerkship under my supervision, Name of hospital / Institution Address (street, city, Zip code) Phone / Fax number between ..... Dates of attendance The clerkship program covers Internal Medicine. Name and title Institution seal Signature Date For Office Use Only Approved / Disapproved

Name and title

Date

Signature of School Official

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

### European Program Academic Year 2023/2024

This is to certify that Mr. /		 Name of student		
has attended 60 hours of sum	nmer clerkship under n	ny supervision,		
at	Name of hospital / Institu			
	Address (street, city, Zip o	·		
	Phone / Fax number			
between	ites of attendance			
The clerkship program covers S	<u>Surgery.</u>			
Signature	Name and title	Institution seal	Date	
For Office Use Only				
Approved / Disapproved				
Signature of School Official	Name and	title	Date	

# Summer Professional Clerkship Certificate 4<sup>th</sup> Year Furopean Program

### European Program Academic Year 2023/2024

TT	36 /36		
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 / In:		
	Address (street, city, Z		
	Phone / Fax num		
between			
	Dates of attendance		
The clerkship program o	overs Pediatrics.		
C: markens	Name and title	Institution_seal	Data
Signature	Name and title	institution seal	Date
	T 044 T		
	For Office Use	Only	
Approved / Disapprov	<b>red</b>		
	<u></u>		
Signature of School Officia	l Name	and title	Date

### Summer Professional Clerkship Certificate 5<sup>th</sup> Year European Program Academic Year 2023/2024

## The Office of the Dean

To:

The Medical University of Silesia in Katowice, POLAND			
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, Z		
	Phone / Fax numb	per	
between	Dates of attendance		
The clerkship program cover	rs Intensive Care.		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
	roi Office Ose	Omy	
Approved / Disapproved			
Signature of School Official	Name a	and title	Date

### Summer Professional Clerkship Certificate 5<sup>th</sup> Year European Program Academic Year 2023/2024

	•			
This is to certify that Mr.	/ Ms	Name of student		
has attended 60 hours of su	mmer clerkship under	my supervision,		
at	Name of hospital / Insti			
	Address (street, city, Zip	code)		
	Phone / Fax numbe			
between	Dates of attendance			
The clerkship program covers				
Signature	Name and title	Institution seal	Date	
For Office Use Only				
Approved / Disapproved				
Signature of School Official	Name an	d title	Date	