Summer Professional Clerkship Certificate 1st Year International Program

International Program Academic Year 2023/2024

This is to certify tha	t Mr. / Ms	Name of student	
has attended 120 hour	s of summer clerkship und	ler my supervision,	
at	Name of hospital / Ins		
	Address (street, city, Z		
	Phone / Fax num	ber	
between	Dates of attendance		
	covers Basic Patient Care (n		
Signature	Name and title	Institution seal	Date
	_		
	For Office Use	Only	
Approved / Disappro	ved		
Signature of School Offici	al Name	and title	Date

Summer Professional Clerkship Certificate 2nd Year

International Program Academic Year 2023/2024

This is to certify that Mr.	/ Ms		
		Name of student	
has attended 30 hours of sur	mmer clerkship under	my supervision,	
at			
	rvaine of nospital / hist.	itution	
	Address (street, city, Zip		
	Phone / Fax number	er	• • • • • • • • • • • • • • • • • • • •
between			
D	ates of attendance		
The clerkship program covers	Basic Health Care – Fi	irst Aid (emergency medi	cine).
Signature	Name and title	Institution seal	Date
	For Office Use (Only	
Approved / Disapproved			
Approved/Disapproved			
Signature of School Official	Name a	nd title	Date

Summer Professional Clerkship Certificate 2nd Year

International Program Academic Year 2023/2024

This is to certify that Mr.	/ Ms	Name of student	
has attended 90 hours of sur	mmer clerkship under	my supervision,	
-1			
at	Name of hospital / Insti		••••••
	Address (street, city, Zip		
	Phone / Fax number	er	
between			
	Pates of attendance	••••••	
The clerkship program covers	Basic Health Care – Fo	umily Medicine (OCP).	
Signature	Name and title	Institution seal	Date
	For Office Use (Only	
		·	
Approved / Disapproved			
Approved/Disapproved			
Signature of School Official	Name a	nd title	Date

Summer Professional Clerkship Certificate 3rd Year

International Program Academic Year 2023/2024

This is to certify that N	/Ir. / Ms	Name of student	
has attended 120 hours o	f summer clerkship und	ler my supervision	
nas attended 120 hours o	i summer cierksinp und	iei iity supervision,	
at	Name of hospital / Ins		
	Address (street, city, Z	iip code)	
	Phone / Fax num	ber	
between	Dates of attendance		
The clerkship program cov	<u>ers Internal Medicine.</u>		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
		•	
Approved / Disapproved	1		
Signature of School Official	Name	and title	Date

Summer Professional Clerkship Certificate 4th Year

International Program Academic Year 2023/2024

This is to certify that Mr	. / Ms		
		Name of student	
has attended 60 hours of su	ımmer clerkship unde	r my supervision,	
at			
	Name of hospital / Inst	titution	
	Address (street, city, Zi		
	Phone / Fax numb	er	
between	Dates of attendance		
The clerkship program cover	s Intensive Care.		
			
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
Approved / Disapproved			
Signature of School Official	Name a	and title	Date

Summer Professional Clerkship Certificate 4th Year

International Program Academic Year 2023/2024

This is to certify that M	r. / Ms	Name of student	
has attended 60 hours of s	summer clerkship unde	r my supervision,	
at	Name of hospital / Ins		
	Address (street, city, Z		
	Phone / Fax numb	oer	
between	Dates of attendance		
The clerkship program cove	ers Pediatrics.		
Signature	Name and title	Institution_seal	 Date
Signature	ivanie and title	institution seal	Date
	For Office Use	Only	
Approved / Disapproved			
Signature of School Official	Name a	and title	Date

Summer Professional Clerkship Certificate 5th Year

International Program Academic Year 2023/2024

This is to certify that M	Mr. / Ms	Name of student	
has attended 60 hours of	summer clerkship unde	er my supervision,	
at			
at	Name of hospital / Ins		•••••
	Address (street, city, Z		
	Phone / Fax num		
between	Dates of attendance		
The clerkship program cov	vers Surgery.		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
Approved/Disapprove	d		
Signature of School Official	Name	and title	Date

Summer Professional Clerkship Certificate 5th Year International Program Academic Year 2023/2024

This is to certify that I	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 num		
between	Dates of attendance		
The clerkship program co	vers OB/GYN.		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
Approved/Disapprove	d		
Signature of School Official	Name	and title	Date