Summer Professional Clerkship Certificate
1st Year
International 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,

at …………………………………………………………………………………………….
Name of hospital / Institution

……………………………………………………………………………………………...
Address (street, city, Zip code)

……………………………………………………………………………………………...
Phone / Fax number

between ……………………………………………………….. .
Dates of attendance

The clerkship program covers Basic Patient Care (nursing practice).

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
2nd Year
International 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 30 hours of summer clerkship under my supervision,

at …………………………………………………………………………………………….
Name of hospital / Institution

……………………………………………………………………………………………...
Address (street, city, Zip code)

……………………………………………………………………………………………...
Phone / Fax number

between ……………………………………………………….. .
Dates of attendance

The clerkship program covers Basic Health Care – First Aid (emergency medicine).

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
2nd Year
International 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 summer clerkship under my supervision,

at ……………………………………………………………………………………………….
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 (OCP).

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
3rd Year
International 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,

at ……………………………………………………………………………………………….
Name of hospital / Institution

……………………………………………………………………………………………...
Address (street, city, Zip code)

……………………………………………………………………………………………...
Phone / Fax number

between ……………………………………………………….. .
Dates of attendance

The clerkship program covers Internal Medicine.

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
4th Year
International 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 60 hours of summer clerkship under my supervision,

at …………………………………………………………………………………………….
Name of hospital / Institution

……………………………………………………………………………………………...
Address (street, city, Zip code)

……………………………………………………………………………………………...
Phone / Fax number

between ……………………………………………………….. .
Dates 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 Professional Clerkship Certificate
4th Year
International 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 60 hours of summer clerkship under my supervision,

at …………………………………………………………………………………………….
Name of hospital / Institution

……………………………………………………………………………………………...
Address (street, city, Zip code)

……………………………………………………………………………………………...
Phone / Fax number

between ……………………………………………………….. .
Dates of attendance

The clerkship program covers Pediatrics.

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
5th Year
International 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 60 hours of summer clerkship under my supervision,

at ……………………………………………………………………………………………….
Name of hospital / Institution

…………………………………………………………………………………………………...
Address (street, city, Zip code)

…………………………………………………………………………………………………...
Phone / Fax number

between ………………………………………………………….. .
Dates of attendance

The clerkship program covers Surgery.

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
5th Year
International 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 60 hours of summer clerkship under my supervision,

at ……………………………………………………………………………………….
Name of hospital / Institution

…………………………………………………………………………………………...
Address (street, city, Zip code)

…………………………………………………………………………………………...
Phone / Fax number

between ……………………………………………………….. .
Dates of attendance

The clerkship program covers OB/GYN.

Signature	Name and title	Institution seal	Date

For Office Use Only

Approved / Disapproved

Signature of School Official	Name and title	Date