Summer Professional Clerkship Certificate 1st Year European Program Academic Year 2024/2025

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 2nd Year European Program Academic Year 2024/2025

This is to certify that M	r. / Ms		
	,	Name of student	
has attended 90 hours of p	orofessional 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 cove	<u>rs Basic Health Care – F</u>	amily Medicine.	
 Signature	Name and title	Institution seal	Date
· ·			
	For Office Use (Only	
Annuared / Disannuared			
Approved / Disapproved			
Signature of School Official	Name a	nd title	Date

Summer Professional Clerkship Certificate 2nd Year European Program Academic Year 2024/2025

This is to certify that Ma	r. / Ms		
		Name of student	
has attended 30 hours of p	rofessional summer cle	erkship under my super	vision,
at	Name of hospital / Ins		
	rume or neoprati / me		
	Address (street, city, Zi		
	Phone / Fax numb	er	
between			
	Dates of attendance		
The classical and an account of the control of the	ua Basia Haalda Cana - E	linna Ald	
The clerkship program cover	<u>rs Basic Health Care – F</u>	<u>irst Aia.</u>	
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
		- 9	
Annuared / Disannuared			
Approved / Disapproved			
Signature of School Official	Name a	and title	Date

Summer Professional Clerkship Certificate 3rd Year European Program

Academic Year 2024/2025

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 4th Year European Program

Academic Year 2024/2025

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, Name of hospital / Institution Address (street, city, Zip code) Phone / Fax number between Dates of attendance The clerkship program covers Surgery. 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 4th Year European Program

European Program Academic Year 2024/2025

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	ip code)		
	Phone / Fax numl	per		
between	Dates of attendance			
The clerkship program cove	rs 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 European Program Academic Year 2024/2025

This is to certify that I	Mr. / Ms	Name of student	
has attended 60 hours of	summer clerkship under	r my supervision,	
at	Name of hospital / Inst		
	Address (street, city, Zi		
	Phone / Fax numb	er	
between	Dates of attendance		
The clerkship program co	vers Intensive Care.		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
	Tor Office Osc (Only	
Approved / Disapprove	d		
Signature of School Official	Name_a	and title	Date

Summer Professional Clerkship Certificate 5th Year European Program Academic Year 2024/2025

	•		
This is to certify that	Mr. / Ms	Name of student	
has attended 60 hours o	of summer clerkship under	r my supervision,	
at	Name of hospital / Ins	titution	
	Address (street, city, Zi	p code)	
	Phone / Fax numb		
hetween			
between	Dates of attendance	••••••	
The clerkship program co	overs OB/GYN.		
<u> </u>	77075 G 27 G 11 W		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
Approved / Disapprov	ed		
Signature of School Official	Name a	and title	Date