Summer Professional Clerkship Certificate
1st 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 professional 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.

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
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 90 hours of professional 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.

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
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 30 hours of professional 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.

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
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,

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
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,

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
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,

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
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,

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
5th 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,

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