Summer Professional Clerkship Certificate 1st Year International Program

International Program Academic Year 2024/2025

This is to south that M	/ N /L-		
This is to certify that M	ir. / Mis	Name of student	•••••
has attended 120 hours of	summer clerkship und	ler my supervision,	
at			
	Name of hospital / In	stitution	
	Address (street, city, Z		
	Phone / Fax num		
between			
	Dates of attendance		
The clerkship program cove	ers Basic Patient Care (n	ursing practice).	
	N. Levil		
Signature	Name and title	Institution seal	Date
	Ear Office Hee	Onles	
	For Office Use	Only	
. 1/5!			
Approved / Disapproved			
Signature of School Official	Name	and title	Date

Summer Professional Clerkship Certificate 2nd Year

International Program Academic Year 2024/2025

This is to certify that M	ſr. / Ms	Name of student	
has attended 30 hours of	summer clerkship unde	r my supervision,	
at	Name of hospital / Ins		
	Address (street, city, Z		
	Phone / Fax numb		
between	Dates of attendance		
The clerkship program cov	ers Basic Health Care – F	First Aid (emergency med	<u>licine).</u>
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
	roi Office Ose	Olliy	
Approved/Disapproved	l		
Signature of School Official	Name a	and title	Date

Summer Professional Clerkship Certificate 2nd Year

International Program Academic Year 2024/2025

This is to certify that M	r. / Ms	Name of student	
has attended 90 hours of s	summer clerkship under	my supervision,	
at	Name of hospital / Inst		
	Address (street, city, Zi		
	Phone / Fax numb		
between	Dates of attendance		
The clerkship program cove	ers Basic Health Care – F	amily Medicine (OCP).	
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
Approved / Disapproved			
Signature of School Official	Name a	nd title	Date

Summer Professional Clerkship Certificate 3rd Year

International Program Academic Year 2024/2025

This is to certify that	Mr. / Ms	Name of student	
		Twine of Statem	
has attended 120 hours	of summer clerkship und	er my supervision,	
at	Name of hospital / Ins		•••••
	,, ,, ,,		
	Address (atmost sites 7		
	Address (street, city, Z	ip code)	
	Phone / Fax numl	ber	
between			
	Dates of attendance		
The clerkship program co	wars Internal Medicine		
The Clerkship program co	vers internat vieatethe.		
Signature	Name and title	Institution seal	Date
	For Office Use	Only	
		•	
Approved/Disapprove	od.		
Approved/Disapprove	.u		
Signature of School Official	Name	and title	Date

Summer Professional Clerkship Certificate 4th Year

International Program Academic Year 2024/2025

This is to certify that N	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	ber	
between	Dates of attendance		
The clerkship program cov	ers Intensive Care.		
Signature	Name and title	Institution seal	Date
Signature	Name and the	histitution scar	Date
	For Office Use	Only	
Approved / Disapproved	I		
Signature of School Official	Name	and title	Date

Summer Professional Clerkship Certificate 4th Year

International Program Academic Year 2024/2025

This is to certify that Mr	. / Ms	Name of student	
		Name of student	
has attended 60 hours of su	ımmer clerkship unde	r my supervision,	
at			
	Name of hospital / Ins	titution	
	Address (street, city, Zi		
	Phone / Fax numb	er	•••••
between	Dates of attendance		
The clerkship program cover	s Pediatrics.		
Signature	Name and title	Institution seal	Date
	- 100000 00000		
	For Office Head	Osales	
	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 2024/2025

This is to certify that Mr.			
has attended 60 hours of sur	nmer clerkship under m	y supervision,	
at	Name of hospital / Instituti		
	Address (street, city, Zip co	ode)	
	Phone / Fax number		
between	ates 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 2024/2025

This is to souther that	. N / N		
This is to certify that	t Mr. / Ms	Name of student	•••••
has attended 60 hours	of summer clerkship unde	er my supervision,	
at			
	Name of hospital / Ins	stitution	
	Address (street, city, Z	ip code)	
	Phone / Fax numl		
between	Dates of attendance		
The clerkship program o	covers OB/GYN.		
Signature	Name and title	Institution seal	Date
	E 066 H	0.1	
	For Office Use	Only	
Approved/Disapprov	ved		
Signature of School Officia	al Name	and title	Date