

Summer Professional Clerkship Certificate
1st Year
International Program
Academic Year 2025/2026

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
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For Office Use Only

Approved / Disapproved

_____ Signature of School Official	_____ Name and title	_____ Date
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Summer Professional Clerkship Certificate
2nd Year
International Program
Academic Year 2025/2026

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
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For Office Use Only

Approved / Disapproved

_____ Signature of School Official	_____ Name and title	_____ Date
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Summer Professional Clerkship Certificate
2nd Year
International Program
Academic Year 2025/2026

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
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For Office Use Only

Approved / Disapproved

_____ Signature of School Official	_____ Name and title	_____ Date
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Summer Professional Clerkship Certificate
3rd Year
International Program
Academic Year 2025/2026

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
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For Office Use Only

Approved / Disapproved

_____ Signature of School Official	_____ Name and title	_____ Date
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Summer Professional Clerkship Certificate
4th Year
International Program
Academic Year 2025/2026

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
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For Office Use Only

Approved / Disapproved

_____ Signature of School Official	_____ Name and title	_____ Date
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Summer Professional Clerkship Certificate
4th Year
International Program
Academic Year 2025/2026

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
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For Office Use Only

Approved / Disapproved

_____ Signature of School Official	_____ Name and title	_____ Date
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Summer Professional Clerkship Certificate
5th Year
International Program
Academic Year 2025/2026

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
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For Office Use Only

Approved / Disapproved

_____ Signature of School Official	_____ Name and title	_____ Date
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Summer Professional Clerkship Certificate
5th Year
International Program
Academic Year 2025/2026

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
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For Office Use Only

Approved / Disapproved

_____ Signature of School Official	_____ Name and title	_____ Date
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