

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

For Office Use Only

Approved / Disapproved

Signature of School Official

Name and title

Date

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

For Office Use Only

Approved / Disapproved

Signature of School Official

Name and title

Date

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

For Office Use Only

Approved / Disapproved

Signature of School Official

Name and title

Date

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

For Office Use Only

Approved / Disapproved

Signature of School Official

Name and title

Date

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

For Office Use Only

Approved / Disapproved

Signature of School Official

Name and title

Date

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 _____

For Office Use Only

Approved / Disapproved

Signature of School Official _____ Name and title _____ Date _____

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

For Office Use Only

Approved / Disapproved

Signature of School Official

Name and title

Date

**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 _____

For Office Use Only

Approved / Disapproved

Signature of School Official _____ Name and title _____ Date _____