

Summer Clerkship Certificate
1st Year

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 Nursing Practice.

Signature Name and title Institution seal Date

For Office Use Only

Approved / Disapproved

Signature of School Official Name and title Date

Summer Clerkship Certificate
2nd Year

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 *Emergency Medicine*.

Signature Name and title Institution seal Date

For Office Use Only

Approved / Disapproved

Signature of School Official Name and title Date

Summer Clerkship Certificate
2nd Year

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 Outpatient Care Practice.

Signature Name and title Institution seal Date

For Office Use Only

Approved / Disapproved

Signature of School Official Name and title Date

Summer Clerkship Certificate
3rd Year

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 Clerkship Certificate
4th Year

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 Clerkship Certificate
4th Year

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 Clerkship Certificate
5th Year

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 Clerkship Certificate
5th Year

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