



International Relations Office

Chalubińskiego 6a, 50-368 Wrocław
T: +48 71 784 11 42, F: +48 71 784 10 13, ru-m@umed.wroc.pl www.umed.wroc.pl

CLINICAL TRAINING – CERTIFICATE OF COMPLETION

STUDENT INFORMATION

Surname			
First name(s)			
Faculty			
Year of study		Date of birth	

HOST INSTITUTION INFORMATION

Name							
Address							
City			Country				
Phone number							
Email address							
University hospital		Yes	No				

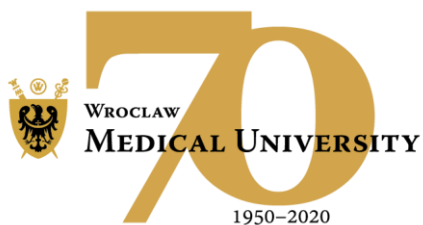
INFORMATION

Clinical Training supervisor/Evaluator							
Surname and names(s)							
Email address							
Hospital ward/unit				Phone no.			
Start date of rotation			End date				
Medical field of the Clinical Training						No. of weeks/hours	

COMMENTS ON STUDENT'S PERFORMANCE

(acquired skills, trained medical procedures, strengths/weaknesses of the student and overall evaluation: poor, average, good, outstanding)

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VERIFICATION (all fields mandatory)

<p>I hereby certify that all the above information is correct to the best of my knowledge.</p>	<p>Date, signature and Host Institution's stamp</p>
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Instructions: Please FILL in all required information. Incomplete forms will NOT be recognized by the WMU. Official stamp of the hosting institution is REQUIRED for the form to be recognized as an official document. Any corrections on the form should be verified with a stamp, date and initials. The student is responsible to return the form to the WMU in person.