**WARSZAWSKI UNIWERSYTET MEDYCZNY**
**MEDICAL UNIVERSITY OF WARSAW**

**Faculty of Medicine**
**61 Żwirki i Wigury**
**02-091 Warsaw, Poland**

## CERTIFICATE OF THE Specialty chosen by a student COMPLETION

STUDENT INFORMATION

| | | | | | |
|---|---|---|---|---|---|
| Index number | | Year of study | | Group | |

| | |
|---|---|
| Name | |
| Date of birth | |
| Practice for the Academic year | |

HOST INSTITUTION INFORMATION

| | | | |
|---|---|---|---|
| Name | | | |
| Address | | | |
| city | | Country | |
| Phone number | | e-mail address | |

CLERKSHIP SUPERVISOR INFORMATION

| | | | |
|---|---|---|---|
| Surname and name | | | |
| e-mail address | | Phone number | |
| Hospital Ward | | | |
| Clerkship start date (dd/mm/yyyy) | | Clerkship end date (dd/mm/yyyy) | |
| Medical field of the clerkship* (i.e. Pediatrics, Internal Medicine, Surgery, Family Medicine) | | Number of hours | |

*program of the summer clerkships is additional document which should be submitted by Student together with this form

VERIFICATION

| | |
|---|---|
| **I certify that all the above information is correct to the best of my knowledge and that the student completed the summer clerkship in compliance with the Medical University of Warsaw summer clerkship program.** | Host Institution`s stamp |
| Signature / Date | |

**Instructions:** ALL FIELDS MUST BE FILLED OUT. Incomplete form will NOT be accepted by the Medical University of Warsaw. 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.