**CLINICAL TRAINING – CERTIFICATE OF COMPLETION**

**STUDENT INFORMATION**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Surname | |  | |  | |
| First and middle name(s) | |  | |  | |
| Year of study\* |  |  | Date of birth (dd/mm/yyyy) |  |  |

\*At the time of completing clinical training

**HOST INSTITUTION INFORMATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name |  | | | | | |  |
| Address |  | |  |  |  | | |
| City |  | |  | County |  |  | |
| Street |  | |  | Number |  |  | |
| Phone number |  | |  |  |  |  | |
| **University hospital** | **Yes** |  |  |  |  |  | |

**INFORMATION**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Clinical Training supervisor information | |  | | | | | |
| Surname and names(s) |  |  | | | | | |
| Email address |  |  | | | | | |
| Hospital ward (if applicable) |  |  | Phone no. |  | | | |
| Start date (dd/mm/yyyy) |  |  | End date (dd/mm/yyyy) | | |  | |
| Medical field of the Clinical Training\*\* |  |  | | | No. of hours | |  |

**COMMENTS ON STUDENT’S PERFORMANCE**

|  |  |
| --- | --- |
|  |  |
|  |  |
|  |  |
|  |  |
| Please continue on the back if necessary |  |

**VERIFICATION** (all fields mandatory)

|  |  |  |
| --- | --- | --- |
| I hereby certify that all the above information is correct to the best of my knowledge and that the student is accepted for the clinical training in compliance with the MUL’s requirements. I confirm the training was conducted in English. | | **Host Institution’s stamp** |
| Supervisor Signature | Date |  |

**Instructions:** Please FILL in all required information. Incomplete forms will NOT be recognized by the MUL. Official stamp of the hosting institution is REQUIRED for the form to be recognized as an official document. Please consult appropriate clinical training outlines for details on requirements (no. of hours, field of medicine etc.). Please do not use whiteout. Any corrections on the form should be verified with a stamp, date and initials. The student is responsible to return the form to the MUL in person. **Contact information**: Medical University of Lodz, Administrative Centre for Studies in English, 1 Hallera Sq. 90-647 Lod,z Poland; e-mail: [*deans.office@umed.lodz.pl*](mailto:deans.office@umed.lodz.pl)*;* phone no.: +48 42 272 50 57