Medical University of Warsaw
2nd Faculty of Medicine
61 Zwirki i Wigury 61
02-091 Warsaw, Poland

CERTIFICATE OF THE SUMMER CLERKSHIP COMPLETION

STUDENT INFORMATION

Surname and name	
Date of birth	
Year of study	

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.