



Spitalgasse 23, A-1090 Wien

## CLERKSHIP CERTIFICATE

This is to certify, that

Mr / Mrs

\_\_\_\_\_

First Name

Last Name

born

\_\_\_\_/\_\_\_\_/\_\_\_\_  
month day year

participated in a clerkship

from

\_\_\_\_/\_\_\_\_/20\_\_\_\_  
month day year

to

\_\_\_\_/\_\_\_\_/20\_\_\_\_  
month day year

at: Hospital:

\_\_\_\_\_

Department:

\_\_\_\_\_

Town:

\_\_\_\_\_

State:

\_\_\_\_\_

The student was trained in the following clinical skills:

- taking the medical history
- physical examination
- drawing blood from peripheral veins
- i.m. & s.c. injections
- others:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The student completed the clerkship with / without success.

Additional remarks:

\_\_\_\_\_  
\_\_\_\_\_

Supervising Physician:

Head of department:

\_\_\_\_\_

Stamp

\_\_\_\_\_

Date, Name and Signature

Date, Name and Signature