MEDIZINISCHE UNIVERSITÄT WIEN

Matr.Nr.: .....

# CLERKSHIP CERTIFICATE

This is to certify, that

Mr/Mrs _____
First name Last name

born ..... / ..... / .....
month day year

participated in a clerkship

from ..... / ..... / .....
month day year

to ..... / ..... / .....
month day year

at: Hospital:
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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:

..... .....
Date, name, and signature Date, name, and signature

Seal

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