Full name: ………………………………………………………………………………………………………………………

Address: ……………………………………………………………………………………………………………………………

Post code: ……………………

Academic year: …………………

Study programme: **General Medicine**

Study group: ………………

**PROOF**

of the 2-week summer clerkship in **paediatrics** for 5th year students, taken

from …………………………… to ……………………………………

Thereby I confirm that the said student passed the summer clerkship at the wards/clinic of our health care facility during the above mentioned period and as prescribed by the syllabus stated by the Faculty.

Evaluation of student’s performance by the clerkship principal:

………………………………………………… ………………………………………

health care facility stamp and signature