to:
Behörde für Gesundheit und Verbraucherschutz
Landesprüfungsamt für Heilberufe
Billstraße 80
20539 Hamburg

_____
(Name of the medical school or teaching hospital)

Certificate concerning practical training

The Student of Medicine: _____

Date of birth: _____

Place of birth: _____

has regularly participated in the following institution, under my supervision and guidance in the training in:

_____
(Name of specialty)

Duration of the education: from: _____ **to:** _____

Missed days of education: from: _____ **to:** _____

This education comprised the following:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(more space on reverse side)

This hospital, the training has been located, is a Teaching Hospital of the Medical Faculty of:

_____
(Name of the University)

_____
(Date, Place)

_____
(Signature of the physician in charge of the medical education)

Seal of the medical school