Formular

to:
Hessisches Landesprüfungs- und
Untersuchungsamt im Gesundheitswesen
Walter-Möller-Platz 1
FRG-60439 Frankfurt am Main

Certificate

Name: ______________________________

Surname: ______________________________

date of birth: ______________________________

place of birth: ______________________________

completed during the last year of his/her clinical studies a subinternship/elective in

name of specialty: ______________________________

from ____________________ **to** ____________________

name of medical school or teaching hospital: ______________________________

This education comprised the following:

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(more space on reverse side)

Missed days of education (number): __________

Date, Place: ______________________________

Seal of the medical school/teaching hospital

Signature of physician in charge of medical education