to:
Hessisches Landesprüfungs- und
Untersuchungsamt im Gesundheitswesen
Walter-Möller-Platz 1
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:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

(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