to:
Hessisches Landesamt für Gesundheit und Pflege

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 speciality _____

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