JOHANNES KEPLER
UNIVERSITÄT LINZ

VERIFICATION OF SUCCESSFUL COMPLETION OF THE CLINICAL TRAINEESHIP

Student ID Number:							

Last Name:	First Name(s):

Date of Birth:		
day	month	year

Clinical Traineeship[1] from:			to:		
day	month	year	day	month	year
Number of days worked:					
Discipline/Specialization:					

Hospital name:	
Hospital address:	
Department/University Clinic:	Name of Department Management/Head of Clinic/Medical Management:
Bed Unit: O YES O NO (Please tick the box!)	

Additional remarks:

_____ _____

Location, Date

Signature and official stamp
Department Head/Head of Clinic/
Medical Management

Please do not fill out this section. For use to verify submission by the JKU Department of Examination and Recognition Services!

_____ _____ _____

Abbreviation Number of Clinical Traineeship weeks ECTS Credits

[1] Traineeship in accordance with the Austrian Medical Practitioners' Act § 49 Para. 4.