



UNIVERZITA KARLOVA  
I. lékařská fakulta

Příloha č. 2

## TRAINEESHIP CERTIFICATE

### I. Name, address and period

Name of the trainee:

Name of the receiving institution :

Department/hospital ward of the receiving institution:

1.....

2.....

3.....

Address of the receiving institution:

website:

phone/email :

Start and end of the traineeship:

from

.....

till [day/month/year].....

**II. Detailed programme of the traineeship period:**

**III. Knowledge, skills (intellectual and practical) and competences achieved:**

**IV. Evaluation of the trainee:**

**V. Name and signature of the responsible person at the receiving institution:**

Date:

Stamp: