**STATEMENT**

This form should be completed, signed and stamped by an authorised representative of an accredited health service institution located in an EU/USA Member State, Norway or Switzerland, providing the traineeship

**I. Data of the state-recognised institute of higher education providing accreditation to the health institution of the traineeship**

Name:

Full address:

Data of state accreditation document

Number:

Date:

**II. Data of the accredited health institution providing traineeship**

Name:

Full address:

Data of accreditation document issued by the relevant state:

Number:

Date:

Data of accreditation

Field (surgery, etc.):

Length (start and expiry):

As the authorised representative of the above named accredited Medical School providing the training, I hereby declare that the data included in this document are true and correct in every respect.

* I hereby declare that our institution **is able to provide** the skills of the ……………………………………………… subject /subjects defined in the competence list in the appendix nr.3. of the 2010/10/VI. MAB order.
* I hereby declare that our institution **is not able to provide** the skills of the ……………………………………………… subject /subjects defined in the competence list in the appendix nr.3. of the 2010/10/VI. MAB order **entirely**.

Name: Signature:

Title/position:

Organisational unit:

Date:

Institute stamp: