**STATEMENT**

This form should be completed, signed and stamped by an authorised representative of the

accredited Medical School

*of any EU Member State, Norway, Switzerland or USA,*

providing the training as part of the medical training curriculum

**Data of the state-recognised Medical School providing the training**

Name:

Full address:

Data of state accreditation document

Number:

Date:

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 ensure the acquirement of the skills in Surgery defined in the list below.

**Practical syllabus of the famulation**

**(Surgery)**

*Recommended practical activities:*

*- Examination of acute surgical patient*

*- Examination of elective surgical patient*

*- Wound care*

*- Participation in the work of the surgical outpatient clinic*

*- Surgery assistance*

*- Surgery administration*

*- Postoperative care, medication*

Name: Signature:

Title/position:

Organisational unit:

Date:

Institute stamp: