**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 accredited health service institution providing traineeship, I hereby declare that the data included in this document are true and correct.

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*

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*- 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: