**STATEMENT**

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

accredited University / Medical School

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

providing the practice placement as part of the medical training

**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 Intsitution providing the practice placement, 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: