**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 Institution 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 ensure the acquirement of the skills in the field of Surgery as defined **in the attached Course Requirements**.

*Syllabus for the practice placement in*

*Surgery – 1 month, 168 hours*

*Recommended practical activities include:*

* *examining acute and elective surgical patients*
* *wound dressing*
* *participating in surgical outpatient clinics*
* *assisting in surgeries as second assistant*
* *surgical administration and*
* *postoperative care and medication*

Name: Signature:

Title/position:

Organisational unit:

Date:

Institute stamp: