SEMMELWEIS UNIVERSITY

Faculty of Medicine
OM identification: FI62576

Dean's Office

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 and 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:

1085 Budapest, Üllői út 26.
Tel.: (36-1) 317-9057, 459-1500 / 55238, Fax: (36-1) 266-0441