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 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 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:

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