*Annex 2*

**COMPLETION CERTIFICATE**

**for the trainees of Semmelweis University, Faculty of Dentistry**

***IMPORTANT!***

**The completion certificate has to be submitted to the Education and Further Training Office via e-mail. E-mail address:** [**farkas.izabella@dent.semmelweis-univ.hu**](mailto:farkas.izabella@dent.semmelweis-univ.hu)

**The deadline of the submitting is up to 5th day of the month.**

|  |  |  |
| --- | --- | --- |
| **NAME**: | | **Medical Stamp Number**: |
| FIELD OF SPECIALTY: | | |
| BEGINNING OF THE SPECIALTY TRAINING: year month day | | |
| Accredited place of training providing and certifying the training element: | | |
| **Beginning of the certified period (this month):** | | **year month day** |
| **End of the certified period (this month):** | | **year month day** |
| **Days off during the training period (*indicated exact dates (from – to -*)** | | |
| Day off(s): |  | |
| Statutory Sick Pay day(s): |  | |
| Mandatory course(s): |  | |
| Other: |  | |
| **Based on the above the vocational training element this month COMPLETED NOT COMPLETED** | | |

|  |  |
| --- | --- |
| **TUTOR’s name:** | **Medical Stamp Number:** |
| Completed period under my supervision: | **from**  **to** |

Date:**…………….………………………………..**

trainee’s signature tutor’s signature

P.H. P.H.

I certify:

signature of head of department P.H.