20…./20….academic year……semester

CERTIFICATE OF COMPLETING CLINICAL PRACTICE

Please fill in with block capital letters!

Name of the student:
……

……

Study Program:
……..

Name and code of the clinical practice course:
……

……

Name of the institution (where the clinical practice is held):
……

……..

Address of the institution (postal code, place, street etc.):
……..……...

……..

Chief director of the institution:

……..……..……..…….

Date of the clinical practice: from……. **to** ……
(eg.: 2024.10.01 – 10.12.)
Altogether:……**weeks**……**hours**

Name of the clinical practice leader:…….
Phone number of the clinical practice leader: ……..
Email address of the clinical practice leader: …….....
Stamp number / registration number of the clinical practice leader:
……...

Name of the responsible tutor of the course in the Faculty:

……

Date:……

…….
Signature of the clinical practice leader **Stamp**