………………………………………………………………….…..

Student first and last name

**CLERKSHIP’S COURSE SHEET**

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| **Date** | **List of works** |
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*Unit’s official stamp clinic/department/doctor’s office Supervisor’s stamp and signature clinic/department/doctor’s office*

…………………………………

 *Place and date*

…………………………………………………………

name and surname of the person submitting the statement

STATEMENT

I, the undersigned, hereby certify that I have done clinical clerkship in my time free from classes. At the same time, I am aware that making a false statement may result in disciplinary liability pursuant to Art. 307 of the Act of July 20, 2018 Law on Higher Education and Science.

 ……………………………………

 Signature of the student