**FACULTY OF MEDICINE WITH THE DIVISION OF DENTISTRY
AND DIVISION OF MEDICAL EDUCATION IN ENGLISH**

**OF MEDICAL UNIVERSITY OF BIAŁYSTOK**

**INTERNSHIP JOURNAL**

……………………………………

 (Seal of the Faculty)

Mr/Ms…………………………………………………………………………………………………………………….....

 (name and surname of the intern)

………………………………………………………………………………………………………………………..………….

 (internship started on)

………………………………………………………………………………………………………………………..………….

 (Receiving Institution)

………………………………………………………………………………………………………………………..………….

 (name and surname of Supervisor designated by MUB)

……………………………….………………

 (internship journal issued on)

**Weekly list of practical tasks performed by the intern.**

|  |  |  |
| --- | --- | --- |
| **Data** | **Number of hours** | **List of tasks** |
|  |  |  |

Total hours:

……….……………………………….…… ………………………………….………………

(signature of the intern) (signature of Internship Supervisor

 designated by the Receiving Institution)

**Weekly list of practical tasks performed by the intern.**

|  |  |  |
| --- | --- | --- |
| **Data** | **Number of hours** | **List of tasks** |
|  |  |  |

……….……………………………….…… ………………………………….………………

(signature of the intern) (signature of Internship Supervisor

 designated by the Receiving Institution)

**Weekly list of practical tasks performed by the intern.**

|  |  |  |
| --- | --- | --- |
| **Data** | **Number of hours** | **List of tasks** |
|  |  |  |

……….……………………………….…… ………………………………….………………

(signature of the intern) (signature of Internship Supervisor

 designated by the Receiving Institution)

**Weekly list of practical tasks performed by the intern.**

|  |  |  |
| --- | --- | --- |
| **Data** | **Number of hours** | **List of tasks** |
|  |  |  |

……….……………………………….…… ………………………………….………………

(signature of the intern) (signature of Internship Supervisor

 designated by the Receiving Institution)

**Part I**

…………………………………..……….

 Name of Receiving Institution

**OPINION OF INTERNSHIP SUPERVISOR DESIGNATED BY THE RECEIVING INSTITUTION**

**Intern’s name and surname: ……................................................................................**

*Please complete the table by ticking YES or NO for each of the points.*

|  |  |  |  |
| --- | --- | --- | --- |
| **No.** | **Implementation of internship programme** | **YES** | **NO** |
| 1. | Ability to apply the acquired competences in practice |  |  |
| 2. | Ability to work and communicate in a team |  |  |
| 3. | Ability to organize one’s work effectively |  |  |
| 4. | Ability to complete the assigned tasks |  |  |
| 5. | Progress in the area of practical activities |  |  |
| 6. | Implementation of the internship programme |  |  |

The intern ................................................................................. completed 120 hours of internship from ………………………… to ………………………… .

**Observations concerning the intern:**

........................................................................................................................................................................................................................................................................................................................................................................................................................... .........................................................................................................................................

………………………………………………………… ……………………………………………………………………………….

DateSignature of Internship Supervisor

 designated by the Receiving Institution





**Część II**

…………………………………..……….

Name of Receiving Institution

**CERTIFICATE OF INTERNSHIP COMPLETION**

I hereby confirm that the Intern

………………………………………………………………………………………………………………………………….

*(name and surname)*

of the 5th year of medicine has completed 120 hours of internship at

………………………………………………………………………………………………………………………............

*(name of institution)*

from …………………………………………. to ………………………………………….

No. of internship agreement: ………………………………………….

The internship was carried out as part of the project entitled “Strengthening the competences of medical students of Medical University of Bialystok” co-financed from the Knowledge Education Development 2014-2020 Programme.

…………………………………………………………………………………….

Date and signature of Internship Supervisor

designated by the Receiving Institution















