



**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:

.....

.....

.....

Date

Signature of Internship Supervisor
 designated by the Receiving Institution



.....
Name of Receiving Institution

CERTIFICATE OF INTERNSHIP COMPLETION

I hereby confirm that the Intern

.....
(name and surname)

5th year student of medicine has completed hours/month 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 Białystok” co-financed from the Knowledge Education Development 2014-2020 Programme.

.....

Date and signature of Internship Supervisor
designated by the Receiving Institution

