



## **Medical Intern Certificate**

Name \_\_\_\_\_

Occupation \_\_\_\_\_

Institution's Name \_\_\_\_\_

Address of Institution \_\_\_\_\_

I certify that the person above is taking a medical internship in our institution,

Date \_\_\_\_\_

The Certifier's Signature \_\_\_\_\_

The Certifier's Occupation \_\_\_\_\_