**This certifies that**

|  |
| --- |
| Name Surname |

 **is serving as resident in**

|  |
| --- |
| Name of the Hospital |
| Name of the Department |

**until**

|  |
| --- |
| Date of the end of the residency |

**Date:**

|  |
| --- |
| date when the certificate is signed |

|  |
| --- |
| Signature of the Head of the Department |
| Name of the Head of the Department |