PROTOCOL OF THE SUMMER PRACTICAL TRAINING IN OBSTETRICS AND GYNECOLOGY

Student´s name:____

Date and place of training:____

PGY/VABP2

Date:	Department:	Doctor ´s signature:
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Corfirmation of the whole practice

Signature of the doctor:

Date: Stamp of the department: