INTERNSHIP VALIDATION CERTIFICATE
MEDICAL STUDENT FROM UFR SIMONE VEIL SANTE

Student :

Family name: _____

First name: _____

Academic year: DFGSM2 O DFGSM3 O

DFASM1 O DFASM2 O DFASM3 O

Internship :

Country: _____

Department: _____

_____

_____

Internship dates : _____

Supervisor : _____

VALIDATION OF THE INTERNSHIP : YES O NO O

Comments (mandatory in case of no validation)

Date :

Signature and stamp of the supervisor :