

**MEDICAL AND DENTAL PROFESSIONS BOARD**

**INTERN DUTY CERTIFICATE FOR COMPLETION OF A TWO YEAR INTERNSHIP TRAINING PROGRAMME**

On completion of internship training, please complete in PRINT and return the ORIGINAL FORM duly completed to:

The Registrar, Medical and Dental Professions Board, PO Box 205, Pretoria 0001

553 Madiba Street, Arcadia, Pretoria 0083

**\*\* NO ALTERATIONS TO THIS DOCUMENT WILL BE ACCEPTED.**

NAME OF INTERN: \_\_\_\_\_ REG. No.: IN \_\_\_\_\_

NAME OF ACCREDITED FACILITY: \_\_\_\_\_

I, the undersigned, CEO/Chief Medical Superintendent of the above facility, hereby certify that the said intern completed internship training in the specified departments/domains of this facility for the periods specified, that he/she fulfilled the prescribed requirements, and that all information furnished herein is correct.

**Notes:** A. If the training of an intern had been **unsatisfactory**, a detailed statement should be submitted by the Head of the Department and the CEO/Chief Medical Superintendent of the accredited facility as to the reasons why the training was considered to be unsatisfactory.

B. Although this certificate may be signed by the CEO/Chief Medical Superintendent and Head of Department **one month prior to completion** of internship training, each intern is required to perform his/her duties in a satisfactory manner during the last month of his/her training, failing which the signed Intern Duty Certificate may be withdrawn. In such a case, the intern would be required to complete the additional period of internship training specified by the CEO/Chief Superintendent and Head of Department.

DOMAIN	PERIOD		MONTHS	Signature of Head of Department or Official Deputy that the internship had been completed <b>SATISFACTORILY</b>
	From	To		
<b>1. CLINICAL DOMAINS (4 months each)</b>				
1.1 General Medicine	dd/mm/year	dd/mm/year		
1.2 General Surgery (including surgical trauma)	dd/mm/year	dd/mm/year		
1.3 Obstetrics and Gynaecology	dd/mm/year	dd/mm/year		
1.4 Paediatrics	dd/mm/year	dd/mm/year		
1.5 Family Medicine/Primary Care (3 months duration)	dd/mm/year	dd/mm/year		
1.6 Mental Health (1 month duration)	dd/mm/year	dd/mm/year		
<b>2. ADDITIONAL CLINICAL DOMAINS (two months each)</b>				
2.1 Anaesthesiology	dd/mm/year	dd/mm/year		
2.2 Orthopaedics/Orthopaedic Trauma	dd/mm/year	dd/mm/year		
<b>3. LEAVE TAKEN</b>				
3.1 Vacation leave	dd/mm/year	dd/mm/year	Total No. of weeks	
3.2 Maternity leave	dd/mm/year	dd/mm/year	Total No. of weeks	
3.3 Sick leave	dd/mm/year	dd/mm/year	Total No. of days	

SIGNATURE OF CEO/CHIEF MEDICAL SUPERINTENDENT OR OFFICIAL DEPUTY

OFFICIAL STAMP OF HOSPITAL

DATE

**NB: Please note that the Council, in the normal course of its duties, reserves the right to divulge information in your personal file to other parties.**