Form 10-A1

MEDICAL AND DENTAL PROFESSIONS BOARD

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

NAME OF INTERN (Full names): REG NO: IN **PLEASE COMPLETE IN BLACK BALLPOINT PEN**.

NAME OF ACCREDITED TRAINING COMPLEX:

I, the undersigned, Head of the Training Complex/Designate, hereby certify that the said intern has completed year one of internship training in the specified domains of this facility for the periods specified, that he or she has 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 to the Internship Committee by the Head of the Clinical Domain and the CEO/Medical Director of the accredited facility as to the reasons why the training was considered to be unsatisfactory. If the domain was not completed satisfactorily, the domain should not be signed off.

B. Although this certificate may be signed by the CEO/Medical Director and Head of the Clinical Domain one month prior to completion of internship training, each intern is required to perform his or her duties in a satisfactory manner during the last month of his or her training, failing which the signed Intern Duty Certificate may be withdrawn.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/Medical Director and Head of the Clinical Domain.

DOMAIN	**PERIOD**		**Months**	**Was Internship training completed satisfactorily**		**Signature of Head of Clinical Domain**		
	From	**To**		**Yes (Tick)**	**No (Tick)**	**Name (Print)**	**Signature**	**Date**
1. CLINICAL DOMAINS								
1.1 General Medicine (3 months)								
If training Extended /Interrupted								
1.2 General Surgery (3 months)								
If training Extended /Interrupted								
1.3 Paediatrics (3 months)								
If training Extended /Interrupted								
1.4 Obstetrics & Gynaecology (3 months)								
If training Extended /Interrupted								

2 LEAVE TAKEN		
2.1 Annual leave	Total no. of days taken	
2.2 Maternity leave (if applicable)	Total no. of days taken	
2.3 Sick-leave	Total no. of days taken	
2.4.1 Other leave (specify type)	Total no. of days taken	
2.4.2 Other leave (specify type)	Total no. of days taken	

No alterations to this document will be accepted.

HPCSA
Health Professions Council of South Africa

Form 10-A2

MEDICAL AND DENTAL PROFESSIONS BOARD

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

NAME OF INTERN (Full names): REG NO: IN **PLEASE COMPLETE IN BLACK BALLPOINT PEN**.

NAME OF ACCREDITED TRAINING COMPLEX:

I, the undersigned, Head of the Training Complex/Designate, hereby certify that the said intern has completed year one of internship training in the specified domains of this facility for the periods specified, that he or she has fulfilled the prescribed requirements, and that all information furnished herein is correct. Notes:

C. If the training of an intern had been unsatisfactory, a detailed statement should be submitted to the Internship Committee by the Head of the Clinical Domain and the CEO/Medical Director of the accredited facility as to the reasons why the training was considered to be unsatisfactory. If the domain was not completed satisfactorily, the domain should not be signed off.

D. Although this certificate may be signed by the CEO/Medical Director and Head of the Clinical Domain one month prior to completion of internship training, each intern is required to perform his or her duties in a satisfactory manner during the last month of his or 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/Medical Director and Head of the Clinical Domain.

DOMAIN	**PERIOD**		**Months**	**Was Internship training completed satisfactorily**		**Signature of Head of Clinical Domain**		
	From	**To**		**Yes (Tick)**	**No (Tick)**	**Name (Print)**	**Signature**	**Date**
1. CLINICAL DOMAINS								
1.5 Anaesthesiology (2 months)								
If training Extended /Interrupted								
1.6 Orthopaedics (2 months)								
If training Extended /Interrupted								
1.7 Psychiatry (2 months)								
If training Extended /Interrupted								
1.8 Family Medicine/Primary care (6 months)								
If training Extended /Interrupted								

2 LEAVE TAKEN		
2.1 Annual leave	Total no. of days taken	
2.2 Maternity leave (if applicable)	Total no. of days taken	
2.3 Sick-leave	Total no. of days taken	
2.4.1 Other leave (specify type)	Total no. of days taken	
2.4.2 Other leave (specify type)	Total no. of days taken	

SIGNATURE OF HEAD OF TRAINING COMPLEX/DESIGNATE **SIGNATURE OF INTERN CURATOR** **OFFICIAL DATE STAMP OF INSTITUTION**

No alterations to this document will be accepted.