Health Professions Council of South Africa

Form 10 A

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satisfactory manner during the last month of his/her training, failing which the signed Intern Duty Certificate may be withdrawn.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 *SATISFACTORILY*
		From	To		
1.	**CLINICAL DOMAINS (4 months each)**				
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*		
2.	**ADDITIONAL CLINICAL DOMAINS (two months each)**				
2.1	Anaesthesiology	*dd/mm/year*	*dd/mm/year*		
2.2	Orthopaedics/Orthopaedic Trauma	*dd/mm/year*	*dd/mm/year*		
3.	**LEAVE TAKEN**				
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.

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