

Appendix 5: Draft Certificate of Completion of Internship

Name of Intern:	
Provisional Registration Number	
Date Internship Commenced:	
Date Due to Complete Internship:	

Mandatory Clinical Experience

	Medicine	Surgery	Emergency Medicine
Accredited Term Name:			
Training Site:			
Total Number of Weeks: (Not including leave)			

	Rotation 4 (if applicable)	Rotation 5 (if applicable)	Rotation 6 (if applicable)	Rotation 7 (if applicable)
Accredited Term Name:				
Training Site:				
Total Number of Weeks: (Not including leave)				

Leave Taken	Annual Leave	Sick Leave	Other (please state)
Total number of days taken during internship:			
Any comments about the leave taken:			

NOTE: If the internship has been completed satisfactorily please complete the next page. If the internship has not been completed satisfactorily please contact the Medical Board of Australia.

Declaration by the Applicant

To: THE MEDICAL BOARD OF AUSTRALIA

I confirm that the details provided in my Record of Completion of the Medical Internship are accurate and that I will have completed at least 48 weeks of full time accredited supervised practice on: _____ (insert date).

Signed: _____ Name: _____

Date: _____ Registration No. _____

Address: _____

Declaration by the Director of Clinical Training (or equivalent)

To: THE MEDICAL BOARD OF AUSTRALIA

I confirm that the details provided in the Record of Completion of the Medical Internship for the intern named above are accurate.

I have reviewed the intern's end of term assessments and consider that the intern has achieved the relevant learning objectives in the Australian Curriculum Framework for Junior Doctors.

Signed: _____ Name: _____

Position: _____

Date: _____

Declaration by the Director of Medical Services (or equivalent)

To: THE MEDICAL BOARD OF AUSTRALIA

I confirm that the details provided in the Record of Completion of the Medical Internship for the intern named above are accurate.

The intern will have completed at least 48 weeks of full time accredited supervised practice on: _____ (insert date), including at least 8-10 weeks in medicine, surgery and emergency medicine.

Signed: _____ Name: _____

Position: _____ Date: _____