Appendix 10 (to Section 14 Paragraph 2 Sentence 2)

Certificate about the nursing service

Name, first Name……,……..

Birth date: ……

Place of birth……

performed nursing duties under my direction as part of his dental training in the hospital or rehabilitation facility listed below.

Duration of the nursing service:

from…… to……

Training has been interrupted:

☐ no

☐ Yes from…… to……

Place, date……,……

seal

or stamp

Name of the hospital/rehabilitation facility ……

……

……

(Signature of the nursing service)