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CERTIFICATE OF INTERNSHIP

(on the institution letter head)

This is to certify that Mr/Ms_____ of _____[Institution name and address] has successfully completed the Internship in the following units/departments as prescribed under regulation 16 and Appendix C of Pharm D Regulations 2008.

Department	**Date**		**Total duration [in months]**
	From	**To**	
Medicine **[Six Months compulsory]**			
Any 3 of the following			
Surgery			
Paediatrics			
OB &G			
Psychiatry			
Skin and VD			
Orthopaedics			

Preceptor **Head of the Institution**

Seal of the Institution