Seychelles Medical and Dental Council
Certificate of Completion of Internship

Surname: .....
Name: .....
Date of birth: .....
Registration Number:.....

This is to certify that the Medical Practitioner named above, after completing medical education and training at the

Name of the University

And having been awarded a

Bachelor of **Medicine and Bachelor of Surgery** Degree

In.....,

has in the year .....,

completed **two years of structured internship** at the **Seychelles Hospital** under the supervision of the

Seychelles Medical and Dental Council

as per the requirements of the Medical Practitioners and Dentists Act, 1994 of Seychelles.

Registrar Date Chairman