U21 Medical Clinical Placement Program Certification Form

Please attach this to the university's application form

To be completed by the applicant

Name (SURNAME, First, Middle)

Date of Birth (DD/MM/YYYY)

Email Address

University which you are applying for

What date would you like to start your clinical placement?

To be completed by the applicant's university

I certify that the above student is a full time medical student with

____

(Name of university)

Number of years to complete the medical degree: _________

The student is currently in year: __________

This student is ☐ of good standing ☐ not of good standing

I would like to recommend this student for a place in the U21 Clinical Placement Program

____

(Signature of Administrator)

____

(Name of Administrator)

University stamp