Evidence of internship form

General Medical Council

Section A

I confirm that

Doctor's name	
Doctor's GMC reference number	

has been engaged in a resident medical capacity in one or more approved hospitals or approved institutions between:

Start date	D D M M Y Y Y Y	Finish date	D D M M Y Y Y Y

and that during that period satisfactory service has been rendered for the following periods of employment:

Rotation	Surgery or Medicine (please tick)	Start date	Finish date	Number of weeks
Example: Obstetrics & Gynaecology	Surgery ☑	0 1 0 1 2 0 0 8	3 0 0 3 2 0 0 8	*13 weeks*
	Medicine ☐			
	Surgery ☐	D D M M Y Y Y Y	D D M M Y Y Y Y	
	Medicine ☐			
	Surgery ☐	D D M M Y Y Y Y	D D M M Y Y Y Y	
	Medicine ☐			
	Surgery ☐	D D M M Y Y Y Y	D D M M Y Y Y Y	
	Medicine ☐			
	Surgery ☐	D D M M Y Y Y Y	D D M M Y Y Y Y	
	Medicine ☐			
	Surgery ☐	D D M M Y Y Y Y	D D M M Y Y Y Y	
	Medicine ☐			

Section B

Please list any periods of study, exam preparation or leave taken during the internship

Leave	Start date	Finish date	Number of weeks
Example: Study leave	01 01 6008	15 06 2008	*2 weeks*
	DD MM YYYY	DD MM YYYY	
	DD MM YYYY	DD MM YYYY	
	DD MM YYYY	DD MM YYYY	
	DD MM YYYY	DD MM YYYY	

Section C

To be completed by the medical school or institution where you completed your internship

Name of supervising consultant or medical director			
Address of medical school or institution			
Telephone number		Fax number	
Email			
Signature		Date	
Name			
Position held			

Official stamp (Note that we cannot accept this form as evidence without an official stamp)