ESSR EUROPEAN SOCIETY OF MUSCULOSKELETAL RADIOLOGY

Training: Proof of experience

ESSR personal ID: _____

Name subspecialty diploma applicant: _____

Proof of Practice Years

This is to certify that

(Title:) _____ (first name:) _____ (last name:) _____

has been working as supervised staff radiologist in this hospital/institution

from _____ to _____.

_____

Name and address of hospital/institution

_____

Street

_____

Zip Code City Country

Official stamp of hospital/institution:

_____ _____

Signature of authorized representative
Name and function of undersigned in block letters
(Authorized representative of department/hospital/institution)

Signature of authorized representative