Date:

Infection Control Training Certification Letter

Full Name:

Passport No:

Current Year of Course:

Year of Course during Elective Period:

Type of mask and size (if available):

The above named is a medical student of ____
(Name of Medical School)
and will be proficient in relevant infection control measures (including hand washing techniques) and the use of PPE, which includes mask, gown, glove and face shield by the time of the proposed elective.

______________________________	______________________________
Name / Signature / Date	Official School Stamp

To be signed off by Dean's Office or School Registrar with official school stamp