Faculty of Dentistry

ORAL SURGERY PRACTICE EVALUATION SHEET
4 weeks

This is to certify that Mr./Ms. .....
(born on (DD/MM/YYYY) ..... in (city/country) ...../.....)
completed every one of the following tasks as a part of an oral surgery practical training at our institution:

Compulsory tasks to be completed	Stamp and signature of the supervisor
1. Practice in local anaesthesia in dentistry and tooth extraction; related problems	
2. 10 simple extractions	
3. Assistance to dento-alveolar surgery	

The completion of each task must be verified individually with the stamp and the signature of the student's supervisor at the institution.

Period of practice: From (DD/MM/YYYY) ..... to (DD/MM/YYYY) .....
Name of the clinic/hospital in capital letters: .....
.....
.....
Address of the hospital/clinic in capital letters: Country: ..... City:.....
.....
.....
Department: .....
Accreditations of the hospital/clinic: .....
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.....
Name of the supervisor in capital letters: .....
Phone number: .....
E-mail address: .....@.....
Evaluation of the student: .....
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.....
Date: ..... **Signature and stamp** .....