Date:

PERSONAL PROTECTIVE EQUIPMENT (PPE) CERTIFICATION LETTER

Full Name:

Passport No:

Current Year of Course:

Year of Course during Elective Period:

The above named is a medical student of _____
(Name of Medical School)

and will be proficient in the use of PPE and related procedures, which include mask fitting, gowning, gloving and hand washing techniques 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