



Certificate requirement for the Inhousecourse "Clean working"

Trainer:

Teacher (Firstname, Name)

Membershipnumber

Adress

Pharmacy/Hospitalname

Trainingday

Trained Persons:

Name, Firstname

Date of birth

Name, Firstname

Date of Birth

Name, Firstname

Date of Birth

Name, Firstname

Date of birth

Name, Firstname

Date of Birth

Name, Firstname

Date of Birth

We confirm
that the Training has been carried out

per Fax to: 0049 40/79 14 36 01

Date, Stamp, Signature