

# Certificate requirement for the Inhousecourse "Clean working"

**Trainer:**

\_\_\_\_\_  
 Teacher (Firstname, Name)

\_\_\_\_\_  
 Pharmacy/Hospitalname

\_\_\_\_\_  
 Membershipnumber

\_\_\_\_\_  
 Trainingday

\_\_\_\_\_  
 Adress

**Trained Persons:**

\_\_\_\_\_  
 Name, Firstname

\_\_\_\_\_  
 Name, Firstname

\_\_\_\_\_  
 Date of birth

\_\_\_\_\_  
 Date of birth

\_\_\_\_\_  
 Name, Firstname

\_\_\_\_\_  
 Name, Firstname

\_\_\_\_\_  
 Date of Birth

\_\_\_\_\_  
 Date of Birth

\_\_\_\_\_  
 Name, Firstname

\_\_\_\_\_  
 Name, Firstname

\_\_\_\_\_  
 Date of Birth

\_\_\_\_\_  
 Date of Birth

We confirm  
 that the Training has been carried out

\_\_\_\_\_  
 Date, Stamp, Signature

per Fax to: 0049 40/79 14 36 01