REPUBLIC OF KENYA

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When replying please quote:

MEDICAL PRACTITIONERS
AND DENTISTS COUNCIL
MP & DB HOUSE,
WOODLANDS RD, OFF LENANA RD
P.O BOX 44839 - 00100 .
NAIROBI

INTERNSHIP COMPLETION CERTIFICATE

NAME: _____

INTERNSHIP TRAINING CENTRE: _____

ADDRESS: _____

This is to certify that the above mentioned doctor has successfully completed his/ her internship training, with internship rotations as follows:

	Discipline	Period			Remarks
1.	Conservative Dentistry	_____	to	_____	_____
2.	Prosthetics Dentistry	_____	to	_____	_____
3.	Periodontology	_____	to	_____	_____
4.	Paediatric Orthodontics	_____	to	_____	_____
5.	Oral & Maxillofacial Surgery	_____	to	_____	_____

Name of the Medical Superintendent/ Administrator: _____

Sign: _____ **Date:** _____

Hospital Stamp:

Registration and Licensing Manager: _____
KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

Sign: _____ **Date:** _____

Chief Executive Officer: _____
KENYA MEDICAL PRACTITIONERS AND DENTISTS COUNCIL

Sign: _____ **Date:** _____

Seal of the Council: