



SHAHEED ZULFIQAR ALI BHUTTO MEDICAL UNIVERSITY

PERFORMA FOR CERTIFICATE OF COMPLETION OF TRAINING (CCT)

The Registrar,
SZABMU,
Islamabad.

Dated _____

Name _____ Father's Name _____

Name of Course _____ Date of Joining _____

Certificate Required for _____

Training Institute/Department: _____

Rotations:-

Sr. #	Name of Department Where rotated	Dates		Performance Grading by immediate Supervisor (Academic/patient care) Good/Satisfactory/Poor	Supervisor Name	Signature of Chairman of Department
		From	To			
1.						
2.						
3.						
4.						
5.						
6.						
7.						
8.						
9.						
10.						
11.						

CME Credit points from _____ to _____

Recommendation/Signature of Head of the Department (with stamp) _____

Orders/Comments

- a. Certificate for MTA
- b. Certificate of completion of training

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