   
Austrian Medical Chamber  
Weihburggasse 10-12  
1010 Vienna

AUSTRIA

**Via the State Medical Chamber**

**Evaluation form**

**Recognition of foreign training periods (§ 14 ÄrzteG)**

*This evaluation form serves as evidence of medical training periods completed in countries -which do not issue/provide* *standardized country-specific certificates.*

|  |  |  |  |
| --- | --- | --- | --- |
| **Personal data:** | | | |
| Surname: |  | | First name: | |  |
| Date of birth: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Training period:** | | | | |
| from: |  | to: |  |

|  |  |  |
| --- | --- | --- |
| **Medical training institution** | | |
|  | Hospital: |  | |
| Department: |  | |
| Name and speciality of the trainer: | | |
|  | | |

|  |  |  |
| --- | --- | --- |
|  | Doctor’s office: |  |
| Practice owner: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| **Officially recognized training institution**\* in the field of: | | | |
|  | | | |
| for |  | months | | |
| since: |  | | (date) |
|  | *\* A verification by the competent authority has to be attached.* | | |

1. **Medical training**

|  |  |  |  |
| --- | --- | --- | --- |
| from: |  | to: |  |

|  |  |
| --- | --- |
| in the field of: |  |

|  |  |  |
| --- | --- | --- |
|  | doctor in training (basic medical training/Turnusarzt) | |
|  | as a specialty registrar (specialist training/Facharztausbildung) | |
|  | other tasks: |  |

|  |  |  |
| --- | --- | --- |
| Extent of employment: |  | % |
|  |  | hours per week | |

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | clinical |  | % |  |  | % outpatient department |
|  | non-clinical |  | % | | | |

|  |  |
| --- | --- |
| Average number of night-/weekend- and holiday shifts per month: |  |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Absence: (total) | | | | | | | | |
| Holiday: |  | days | | | | | | |
| Sick leave: |  | days | | | | | | |
| Maternity/Parental leave: | | | from: |  | to: |  | |  |
| Other reasons: | | |  | | |  | days | |

|  |  |
| --- | --- |
| The training was funded by: | |
|  | the hospital |
|  | a national institution by means of a scholarship (please indicate) |
|  |  |
|  | Others (please indicate) |
|  |  |

1. **Hospital/Doctor‘s office**

|  |  |
| --- | --- |
| Name: |  |
| Address: |  |
|  |  |
| Phone: |  |
| E-mail: |  |
| Website: |  |

|  |
| --- |
| The hospital is under the authority of the following institution: |
|  |

|  |
| --- |
| Name and speciality of the medical director: |
|  |
|  |

|  |
| --- |
| The hospital comprises the following departments: |
|  |

|  |  |
| --- | --- |
| Total number of beds: |  |

1. **Department**

|  |  |
| --- | --- |
| Department name: |  |

|  |
| --- |
| Name and speciality of the head of the department: |
|  |
|  |

|  |  |
| --- | --- |
| Number of beds at the department: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Outpatient department: |  | yes | Number of patients per day: |  |
|  |  | no |  |  |

|  |  |  |
| --- | --- | --- |
| Number of (medical) employees at the department: | | |
| licensed general medical practitioners: |  |
| licensed specialists: |  |
| doctors in training: |  |

|  |
| --- |
| Equipment of the department: |
| Technical facilities: |
|  |
| Field of medical services provided (diagnostic and therapeutic): |
|  |

1. **Job description**

|  |
| --- |
| Detailed description of the doctor’s medical practice, as well as detailed information about acquired knowledge and skills (if required, a catalogue of undertaken surgeries, ultrasounds or other relevant treatments and interventions has to be attached): |
|  |

|  |
| --- |
| Additional qualifications, courses, specialty-related projects or research activities: |
|  |

|  |
| --- |
| Additional notes by the trainer: |
|  |

|  |
| --- |
| This is to certify the accuracy of the statement |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Doctor in training  Name and signature |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Trainer  Name and signature |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Head of the department / Practice owner  Name and signature |

|  |  |  |  |
| --- | --- | --- | --- |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |  |  |  |
| Seal | Date (dd.mm.yyyy) |  | Place |