

# PRINT ON UNIVERSITY'S LETTERHEAD

Date:

## **PERSONAL PROTECTION EQUIPMENT (PPE) CERTIFICATION LETTER**

Full Name:

Passport No:

Current Year of Course:

Year of Course during Elective Period:

The above named is a medical student of \_\_\_\_\_  
(Name of Medical School)  
and will be proficient in the use of PPE and related procedures, which include mask fitting,  
gowning, gloving and hand washing techniques by the time of the proposed elective.

\_\_\_\_\_  
Signature/Date

\_\_\_\_\_  
Official School Stamp

\_\_\_\_\_  
Name/Designation