(Name and address of applicant:)

_____

_____

_____

_____

ESR Personal ID:_____

To: EBR Office
Paseo de Gracia, 86 9ª Planta
08008 Barcelona ESPAÑA
diploma@myebr.org

Date: _____

Proof of Practice Years

This is to certify that

(Title:) _____ (First Name:) _____(Last Name:) _____

has been working as supervised staff radiologist in this hospital / institution from _____ to _____.

Name and address of hospital / institution:

_____

_____

_____
Street

_____
Zip Code City Country

Official stamp of hospital/institution:

_____ _____
Name and function of undersigned in block letters (Authorized representative of department/hospital/institution)

Signature of authorized representative