
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: |       |

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| **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: |       |

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| --- | --- |
| [ ]  | 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 |

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| 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: |       |

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

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

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| The hospital comprises the following departments:  |
|       |

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

1. **Department**

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

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| --- |
| 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: |       |

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

1. **Job description**

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| 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): |
|       |

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

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| Additional notes by the trainer: |
|       |

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| This is to certify the accuracy of the statement |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Doctor in trainingName and signature |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| TrainerName and signature |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Head of the department / Practice ownerName and signature |

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