ViPS-Trial

Certificate of competence

Center:

I confirm with my signature, that I have used the test phase to familiarize myself with the database.

I undertake to keep secret my password and to maintain data protection.

Name, First name / Function	Date	Kind of training	Signature of trained person	Signature of instructor *(Only necessary in case of training through a colleague.)*
Name, First name Function ❍ doctor ❍ non-medical personnel		❍ through colleague* ❍ self-study		

* Prerequisite: The colleague is already trained!

Please fax the filled form to KKS Dresden with fax number +49 351 458-5799.