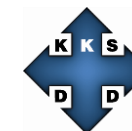


**ViPS-Trial**

**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 <i>(Only necessary in case of training through a colleague.)</i>
Name, First name		<input type="radio"/> through colleague* <input type="radio"/> self-study		
Function <input type="radio"/> doctor <input type="radio"/> non-medical personnel				

\* Prerequisite: The colleague is already trained!

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