

IASSA Certified Training Program
(To be completed by the Mentor in the letter head)

This is to certify that _____
bearing Registration No. _____ with _____ Medical Council,
IASSA Membership no. _____ has completed ____ months training from _____ to
_____ in the field of Sleep Related Breathing Disorders at
_____.

He / She has observed and assisted in different diagnostic and therapeutic procedures being performed in the hospital, as well as participated in different activities during the course of the training.

I certify that the trainee has completed the training program satisfactorily.

Signature with date