Medical University of Warsaw

HEALTH CERTIFICATE

(to be completed by a physician)

1. Family Name..... Given Name……...
2. Gender: Male, Female Title: Mr., Mrs., Ms., Miss
3. Date of Birth: year.....month.....day.....place……
4. Contact address.....

PREVIOUS MEDICAL RECORD

1. Applicant's medical history:
   a. congenital or acquired disability……
   b. chronic conditions: diabetes, asthma, hypertension, rheumatic, allergy, psychiatric, neurological, others……
   c. medication (temporary/longstanding)……
   d. hospitalization, date, diagnosis……
2. Other information……

MEDICAL EXAMINATION

1. Hight……cm weight……..kg
   Blood pressure……..pulse……..per minute
2. Physical exam of the systems……
3. Vision.....glasses/correction Rt.....Lt.....
4. Hearing:.....
5. Cardiovascular system:.....
6. Respiratory system:.....
7. (Chest X-ray report)

VACCINATIONS

Please indicate the date of last vaccination:

Tuberculosis.....

HBV.....

The above mentioned person will be exposed to the following factors that are harmful, disruptive or dangerous for health, including chemical agents – sensitizing irritant, formalin, infectious biological material, working on a display screen and optical microscope.

MEDICAL CONCLUSION (circle the appropriate)

Applicant is in a good health and hence able to commence medical studies – YES/NO

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Date of the next examination.....

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/place and date of examination/ */examining physician's name and signature/*

Official stamp, address, tel.no