**MEDICAL FITNESS CERTIFICATE**

(To be signed by a registered medical practitioner holding a degree not below that of MD)

(TO BE SUBMITTED WITH THE APPLICATION)

**THE PATIENT:**

(Please provide these data exactly as they appear in passport.)  
**First / given name:** ................................................................................................................................... **Familyname/surname:** .......................................................................................................................... **Permanent home address:** ...................................................................................................................... **Date (dd/mm/yyyy) and place of birth**: ..................................................................................................

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I, Dr. ................................................... (address:....................................................................................... ........................................................................................................................................)   
after examining the patient, certify that he/she is free from infectious diseases, is vaccinated against Hepatitis B, has no known **neurological**, **ophthalmological** and **otolaryngological** pathologies, and has no disease or physical or mental infirmity unfitting him/her now or likely to unfit him/her in the future for participation as a student in a training program for medicine / dentistry / pharmacy.

Any chronic diseases the patient is being treated for: ............................................................................. Remarks / Special recommendations / Special needs: ............................................................................ .................................................................................................................................................................... ....................................................................................................................................................................

PLACE AND DATE: .............................................................

.......................................................... DOCTORS’ SIGNATURE AND SEAL

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Declaration by the patient / candidate: I declare that all the statements above are true and correct to the best of my knowledge. I fully understand that I am responsible for the accuracy of all statements given.

PLACE AND DATE: .............................................................

.......................................................... SIGNATURE OF THE PATIENT