**Psychological examination**

(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**: ..................................................................................................



I,................................................... (address:....................................................................................... ........................................................................................................................................)
have physically examined today Mr/Mrs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at my clinic/residence of Mr/Mrs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and I hereby confirm and certify that the patient has no 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 as under:

1. During my examination of Mr/Mrs. \_\_\_\_\_\_\_\_\_\_\_\_\_ I have witnessed clarity of thoughts and clear communications: verbal, as well as emotional.
2. Mr/Mrs. \_\_\_\_\_\_\_\_\_\_\_\_\_ is fit to read, write, understand and sign his/her Will.
3. Mr/Mrs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_ does not require any medical treatment or medication which could adversely affect his/her mental fitness.
4. Mr/Mrs. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ is mentally and emotionally fit to execute his/her Will.

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

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



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