Medical certificate

(To be signed by a registered medical practitioner)

Application number:

The patient:
(Please provide these data exactly as they appear in passport and/or ID card.)

First / given name:
....
Family name / surname:
....
Permanent home address:
....
Date (dd/mm/yyyy) and place of birth:
....
Mother's name
…………………………………………………………………………………………………...

BELOW FIELDS SHOULD BE FILLED OUT BY MEDICAL DOCTOR!
I,
Dr.………………………………………………………………………………………...

(address:………………………………………………………………………………………

………………………………………………………………………………………), after examining the patient, I hereby certify that he/she is free from the following diseases:

- sudden loss of consciousness,
- functional disorders of the upper and lower limbs, more severe changes in the static system,
- normalities of the heart, blood circulation and respiratory system that do not allow physical exertion,
- hearing less than 30 decibels in the speech zone,
- the degree of loss of visual acuity and / or limited visual acuity to such an extent that it may interfere with the work of a group of children,
- color blindness,
- severe mental and psychically disorders,

And has no disease or physical or mental infirmity unfitting him/her now I take note of the above.

Place and date: ....

……………………………………………
Doctors' signature and seal

Declaration by the patient / candidate:

I declare that I do not suffer from dyslexia, dysgraphia, dyscalculia, mental and mental disorders and other partial ability disorders.
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:

……………………………..