#

# CERTIFICATE OF THE MEDICAL AND PSYCHOPHYSICAL CAPABILITIES TO STUDY MEDICINE

# ISSUED BY THE COMPETENT PHYSICIAN OF GENERAL MEDICINE

 Name and surname of the applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth (day, month, year):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address of permanent residence (street, house number, postal code, city, country):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Health requirements for medical studies:

* acceptable eyesight without or with correction;
* ability to distinguish colours (Ishihara test – 24 test plates);
* acceptable hearing without hearing aids or with the use of a hearing aid with the possibility of adapting it to medical instruments;
* normal ability for verbal communication and speech expression without speech impediments and in a well-articulated manner;
* normal function of the musculoskeletal system, torso, upper and lower extremities – preserved functional motility of the vertebral column, upper and lower extremities within the physiological limits, normal gross and fine motor skills of the upper and lower extremities;
* normal balance and stable state of consciousness – absence of severe and permanent conditions;
* normal cognitive functioning;
* normal emotional functioning;
* normal psycho-motoric functioning (entails normal mental function controls of motor and psychological processes within the body);
* absence of allergic reactions to professional allergens – drugs (inhalation and contact);
* regular immunization according to the valid immunization schedule for each candidate.

After examining the applicant, examining the available medical documentation and the questionnaire filled in and signed by the applicant, the competent physician of general medicine delivers an opinion on the medical and psychophysical capabilities to study medicine as follows **(circle A or B)**:

## The applicant has no medical or psychophysical difficulties which are an obstacle to study medicine and the certificate is issued.

1. **The applicant is aware that he/she has health and/or psychophysical difficulties and he/she is personally responsible if they result in difficulties during his/her studies.**

The applicant has the following difficulties:

The certificate shall be issued with the specified warning. The certificate should be accompanied by the relevant medical documentation.

**The University of Zagreb School of Medicine may request an additional examination of health requirements in cases where B certificate was issued.**

Place, country: \_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(day/month/year)*

Health care institution: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stamp of the health care institution:

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# QUESTIONNAIRE

# on the basis of which the competent doctor of general medicine issues the

# Certificate of the Medical and Psychophysical Capabilities to Study Medicine

**Name and surname of the applicant: Date of birth** (day, month, year):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OIB** (if available)**: Address of permanent residence** (street, house number, postal code, city, country):

**E-mail address: Phone number: Name of completed secondary school:** **Study year: School year: \_\_\_\_\_\_\_/\_\_\_\_\_\_\_ City, country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of the university** (*for students who have attended university)*:

**Academic year:** / **City, country:**  Have you ever had the following diseases (circle either YES or NO):

measles - YES NO, mumps – YES NO, rubella – YES NO, chickenpox - YES NO, paediatric paralysis – YES NO,

whooping cough - YES O, hepatitis B – YES NO, tuberculosis YES NO

Please answer the following questions (mark either YES or NO) and provide an explanation if the answer is YES:

|  |  |  |  |
| --- | --- | --- | --- |
| Have you ever had or do you currently have any of the following diseases, conditions, disorders: | YES | NO | If the answer is YES, please explain (diagnosis, stays inhospital, treatment, are you being treated periodically or permanently for this disease, etc.): |
| Respiratory tract (asthma, obstructive bronchitis, etc.) |  |  |  |
| Neurological disorders (epilepsy, febrile convulsions, headaches - recurrent or constant, cerebral paralysis, etc.) |  |  |  |
| Gastrointestinal tract, abdominal organs (ulcer disease, hepatitis, ulcerative colitis, etc.) |  |  |  |
| Endocrine system (diabetes, thyroid diseases, etc.) |  |  |  |
| Heart and vascular diseases (increased arterial pressure, heart defects, rheumatic fever, etc.) |  |  |  |
| Musculoskeletal system (bones, joints (scoliosis, kyphosis), etc.) |  |  |  |
| Urinary and/or reproductive tract (urinary tract, kidneys, reproductive tract infections, etc.) |  |  |  |
| Blood disorders (haematological diseases, anaemia, thrombocytopenia, leukaemia, etc.) |  |  |  |
| Psychological disorders |  |  |  |
| Skin and subcutaneous tissue (acne, dermatitis, eczemas, allergies, etc.) |  |  |  |
| Eye and/or visual system diseases |  |  |  |
| Ear and/or hearing diseases |  |  |  |
| Tonsils, nose, neck diseases |  |  |  |
| Allergies (to food, drugs, plants, animals or any other that have not been mentioned, etc.) |  |  |  |
| Major discrepancies in: body height, body weight (including significant weight loss or increase in the last six months), etc. |  |  |  |
| Difficulties in verbal communication and speech expression |  |  |  |
| Writing and/or reading and/or arithmetic difficulties |  |  |  |

Have you ever been in hospital for treatment? YES NO

If YES, indicate the date, diagnosis and outcome of each treatment:

Are you currently taking any medicines or receiving injections (other than those mentioned above)? YES NO

If YES, indicate which, the reason for taking, dose and frequency:

Have you ever visited a neurologist, psychologist, psychiatrist or other specialist for neurological, emotional, mental or nutritional issues? YES NO

If YES, explain the reasons and treatment:

Have you ever had any restrictions or prohibitions in participation in sports and/or physical education classes? YES NO

If YES, explain the reasons:

*Please note: The competent doctor of general medicine has the right to request additional data and medical documentation from the applicant and to perform an examination before issuing the Certificate of Health and Psychophysical Capabilities to Study Medicine.*

Place, country: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *(day/month/year)*

Applicant’s signature: