UNIVERSITY OF LATVIA
FACULTY OF MEDICINE

MEDICAL REPORT

Applicant's name:	*Surname, given name(s)*	Applicant's date of birth:	*DD/MM/YYYY*

VISION TEST		
Colour vision test is mandatory requirement		
Is the patient's vision impaired?	[ ] Yes → if „Yes", please describe [ ] No	
Colour vision/Ishihara test result:		

HEARING TEST		
Is the patient's hearing impaired?	[ ] Yes → if „Yes", please describe [ ] No	

MEDICAL CONDITION		
Please describe any medication or treatment the patient has received during the past year, or is currently taking:		
Does the patient have history of chronic diseases, symptoms of nervous, emotional or mental abnormality?	[ ] Yes [ ] No	
Is there any evidence of any other diseases, impairment or abnormalities?	[ ] Yes [ ] No	
Does the patient have any illnesses or a condition, which is contagious?	[ ] Yes [ ] No	

CHEST X-RAY RESULTS			
Chest x-ray is a mandatory requirement and the test results are valid for 1 year.			
Chest X-ray result:			
Is there any evidence of tuberculosis?	[ ] Yes [ ] No	Date of examination:	

VACCINATION INFORMATION (REQUIRED VACCINATIONS)

The last TD-Tetanus/Diphtheria vaccination must not be older than 10 years. The last (third) Hepatitis B vaccination must be done within a 10year period. Vaccination report may be substituted with photocopy of the Vaccination Certificate.

Vaccine	**Year of vaccination**			**Booster within the last 10 years**		
	1st	**2nd**	**3rd**			
TD-Tetanus/ Diphtheria				[ ] Yes [ ] No	Date:	
Hepatitis B				[ ] Yes [ ] No	Date:	

GENERAL CONCLUSIONS	
In your expert opinion, is the patient's health condition suitable to commence studies in health sciences?	
[ ] Yes	[ ] No

PERSONAL INFORMATION ABOUT THE PHYSICIAN			
Name:		Email:	
Address:		Date of examination:	
Signature and stamp:			