

## GENERAL MEDICAL CERTIFICATE

**LEGAL NAME** (WRITE NAME EXACTLY AS IT APPEARS ON OFFICIAL DOCUMENTS)

FIRST/GIVEN NAME: \_\_\_\_\_

FAMILY/SURNAME: \_\_\_\_\_

**PERMANENT (HOME COUNTRY) ADDRESS:**

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

**PLACE AND DATE OF BIRTH:** \_\_\_\_\_

(CITY/COUNTRY AND DD/MM/YYYY)

### **DECLARATION BY THE GENERAL PRACTITIONER:**

I confirm that the individual mentioned above is at present free from signs and symptoms of infection. It is hereby certified that he/she is physically and mentally fit to pursue university studies in the field of health sciences.

**Remarks\*:**

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

*\*Please also indicate any special needs or diagnosed learning disability that would affect academic studies.*

**NAME OF THE GENERAL PRACTITIONER:** \_\_\_\_\_

**ADDRESS OF THE PRACTICE:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

(DD/MM/YYYY):

**SIGNATURE AND STAMP OF THE GENERAL PRACTITIONER:** \_\_\_\_\_

Please be informed that, under Hungarian law, higher education institutions providing healthcare education – including the University of Szeged – are required to assess students' fitness for healthcare-related activities. Participation in such programmes is permitted only for students who are certified as fit by a Hungarian occupational health physician authorised to perform the assessment. Fitness for healthcare means that the student poses no infection risk, is mentally and physically capable of providing patient care, and does not endanger patients or themselves.

For this reason, we would like to draw your attention in advance that the medical conditions listed below may render the individual medically unfit for healthcare-related activities:

- Uncorrectable severe sensory impairments (vision, hearing)
- Speech disorders substantially impairing communication
- Mobility impairments interfering with patient care, especially emergency or surgical tasks
- Active or chronic infectious diseases with the risk of transmission (e.g. tuberculosis, chronic hepatitis B or C, HIV infection)
- Seizure disorders (e.g. epilepsy) where seizure freedom cannot be maintained by treatment
- Substance use disorders (incl. alcohol or drug dependence) impairing safe and reliable functioning
- Mental health disorders, where they adversely affect the delivery of safe patient care and/or cannot be reliably controlled with appropriate treatment, including but not limited to:
  - severe autism spectrum disorders, behavioural disorders, or personality disorders
  - psychotic disorders (e.g. schizophrenia), major depressive disorder, or bipolar disorder
  - severe anxiety disorders, obsessive-compulsive disorder, or eating disorders

Medical fitness is assessed individually in all cases, in accordance with applicable Hungarian legislation.

If any of the above-mentioned medical conditions are present or may be present, or if the applicant is uncertain whether any condition they may have could affect their fitness for healthcare practice — given that healthcare fitness is a fundamental prerequisite for pursuing healthcare studies — it is strongly recommended that the applicant request a preliminary health fitness assessment for consultation purposes from the University's occupational health physician already during the application process.

The aim of the pre-assessment is to determine whether the applicant's condition may affect eligibility for healthcare fitness within the selected health sciences training programme. If such a request is submitted, the occupational health physician will contact the applicant by email and request relevant details and supporting medical documentation in English.

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**DECLARATION BY THE APPLICANT:**

I hereby declare that I have read and understood the importance of the above information regarding medical conditions that may affect eligibility for healthcare fitness and that I have the opportunity of requesting a preliminary health fitness consultation.

**One option must be selected by ticking the appropriate box:**

- ☐ I request my preliminary health fitness assessment, and by indicating this request I simultaneously give my explicit consent for the University's occupational health physician to contact me via the email address provided in my application.
- ☐ I do not request a preliminary health fitness assessment.

I certify that all information submitted in this form is true and accurate. I understand and agree that if the University determines that I have provided false or misleading information, this may affect my application and/or student status.

**DATE:** \_\_\_\_\_  
(DD/MM/YYYY)

**SIGNATURE OF THE APPLICANT:** \_\_\_\_\_