



Health questionnaire

for candidates applying for 6-yr Medicine Program at Collegium Medicum in 2024/2025

Instructions

This health questionnaire should be filled with capital letters by a practising physician ONLY. Submit a photocopy of the health questionnaire along with other required documents to the university recruitment system before the application deadline. If your application is accepted (your application status on the recruitment page appears as “admitted”), to secure your place you must deliver the application form along with other required documents (ORIGINALS) until **July 18th, 2024** to:

Instytut Nauk Medycznych (p. 3/16a)
Collegium Medicum UJK w Kielcach
al. IX Wieków Kielc 19A
25-317 Kielce
POLAND

Personal data

Name and
surname

Street address,
including city,
and postal
code

Date of birth (YYYY-MM-DD)
***must be 18 years old on
1st Oct 2024**

Country

Medical record

No

Yes

If, yes describe the type

congenital or acquired
disability

chronic conditions: diabetes,
asthma, hypertension,
rheumatic, allergy,
psychiatric, neurological,
others

medication (temporary/
longstanding)

hospitalization (dates,
diagnosis)

family diseases

No

Yes

If, yes describe the type

other information

Medical examination

General information

Hight in cm

Wight in kg

Pulse

per min

Blood pressure

Physical examination of the systems (insert X if applicable)

Healthy

Further tests needed

Vision (insert X if applicable)

Normal vision

Glasses needed

Rt

Colours

Lt

Was the general blood and urine tests made? (insert X if applicable)

Yes

No

Vaccinations

Vaccine against Hepatitis B is mandatory. In exceptional cases, individual doses can be taken later.

Vaccination against Covid-19 is strongly recommended.

Hepatitis B

1st dose
date

2nd dose
date

3rd dose
date

Vaccine
name and
serial
number

Vaccine
name and
serial
number

Vaccine
name and
serial
number

Covid-19

1st dose
date

2nd dose
date

Vaccine
name and
serial
number

Vaccine
name and
serial
number

Conclusion

Candidate is in a good health and hence able to commence medical studies

I agree

I disagree

Signature

Signature of the physician filling this form

Name

Name of the physician filling this form

Date of Signature

DD

MM

YY

Stamp