The present certificate is a compulsory document to be submitted during application to the Stipendium Hungaricum scholarship. Tempus Public Foundation manages applicants' data based on the Privacy Statement for data management in connection with the Stipendium Hungaricum Programme in force.

Full name of the applicant (as it appears on passport): Muhammad Zakirya				
Date of birth: <u>11/04/2000</u>				
Nationality: Pakistan				

TYPE OF MEDICAL TEST OR VACCINATION	Examination /	RESULT
	VACCINATION DATE	(circle the relevant option)
Tuberculosis (TB) screening (chest X-ray within 3 months)		negative / positive
or		
Quantiferon test		
Please attach the result (not the film) in English/Hungarian.		
SEROLOGICAL TES		
(within 3 months, please attach	results in English)	
HIV		negative / positive
Hepatitis B surface antigen (HBsAg)		negative / positive
Hepatitis C antibody (anti-HCV/ HCV Ab)		negative / positive
VACCINATIONS		
If available please attach Childhood Vaccination/	Immunisation Records in	English.
If the patient is not vaccinated, please consider vac	ccination before arriving i	n Hungary.
Has the patient been vaccinated against diphtheria, tetanus and		Yes / No
pertussis? (dTap/Tdap booster should be given every 10 years)		
Has the patient been vaccinated against MMR (measles, mumps,		Yes / No
rubella)?		
Has the patient been vaccinated against poliomyelitis?		Yes / No
Has the patient been vaccinated against Coronavirus (COVID-		Yes / No
19)?		
Has the patient been vaccinated against Hepatitis B ?		Yes / No
Has the patient been vaccinated against typhoid? Please note,		Yes / No
that in case of patients from endemic countries if the patient had		
not been vaccinated against typhoid, vaccination is compulsory		
after entering Hungary, as part of the healthcare protocol*		

^{*}to be filled out only in case of endemic countries

With my signature I hereb	v declare that the information p	provided in this form is correct.
---------------------------	----------------------------------	-----------------------------------

Date of issue:		
		signature and stamp of examining physician