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

Full name of the applicant (as it appears on passport): ______________________________

Date of birth: ______________________________

Nationality: ______________________________

TYPE OF MEDICAL TEST OR VACCINATION	EXAMINATION / VACCINATION DATE	RESULT (circle the relevant option)
Tuberculosis (TB) screening (chest X-ray within 3 months) or **Quantiferon test** Please attach the result (not the film) in English/Hungarian.		negative / positive
SEROLOGICAL TESTS (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 vaccination before arriving in Hungary.		
Has the patient been vaccinated against **diphtheria, tetanus and pertussis**? (dTap/Tdap booster should be given every 10 years)		Yes / No
Has the patient been vaccinated against **MMR (measles, mumps, rubella)**?		Yes / No
Has the patient been vaccinated against **poliomyelitis**?		Yes / No
Has the patient been vaccinated against **Coronavirus** (COVID-19)?		Yes / No
Has the patient been vaccinated against **Hepatitis B**?		Yes / No
Has the patient been vaccinated against **typhoid**? *Please note, 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******		Yes / No

**to be filled out only in case of endemic countries*

With my signature I hereby declare that the information provided in this form is correct.

Date of issue: ____________________

signature and stamp of examining physician