

[Health Certificate]

Mr./Ms. (Name of physician)

Professional Address

Certifies that Mr./Ms. (Name of applicant):

LAST NAME

FIRST NAME

DATE AND PLACE OF BIRTH

NATIONALITY

ADDRESS

PASSPORT NO.

ALLERGIES/
CHRONIC CONDITIONS

does not suffer from any disease that might impede her/him from her/his stay for the duration of _____ at the University of Innsbruck in order to attend the academic term/s _____

It is also certified that the said person fulfils all the health requirements that are necessary for the above-mentioned stay in Austria in accordance with the current legislation.

Place

Date

Signature

Stamp