

I, \_\_\_\_\_, \_\_\_\_\_, born \_\_\_\_\_  
(name and surname) (father's/mother's name) (date of birth)

make the following

### STATEMENT OF PSYCHOPHYSICAL CAPACITIES

- I feel mentally and physically ready to study Dental Medicine.
- I am familiar with the contents of the Certificate of the competent school doctor on health and psychophysical abilities for the study of medicine, which I enclose with the Application.
- I declare that I have not suffered from, or do not suffer from, mental and/or physical diseases that remain unknown to the competent school doctor, and that could hinder the study of Dental Medicine at the School of Dental Medicine Zagreb and the pursuit of the title of Doctor of Dental Medicine.
- I am ready to assume all responsibility arising from this statement.

In Zagreb, \_\_\_\_\_ 2026

Authorized signature of the applicant

\_\_\_\_\_

#### PERSONAL DATA OF THE APPLICANT:

Address: \_\_\_\_\_

Mobile phone: \_\_\_\_\_