Vzdělávání lékařských zdravotnických pracovníků
- Formuláře žádostí
- Dotaz na stav žádosti

Vzdělávání nelékařských zdravotnických pracovníků
- Formuláře žádostí
- Dotaz na stav žádosti

Akreditovaná zařízení

Akreditace lékařských oborů
- Formuláře žádostí
- Dotaz na stav žádosti

Akreditace nelékařských oborů
- Formuláře žádostí
- Dotaz na stav žádosti

Rezidenční místa

Evidence zdravotnických pracovníků

MINISTERSTVO ZDRAVOTNICTVÍ ČESKÉ REPUBLIKY

EVIDENCE ZDRAVOTNICKÝCH PR

Uložit a tisk

▪ After saving the request stored in the system and can not be changed or further correspondenc

# APPLICATION

**(according to par. 42 subpar. 1- 6 Act. No. 95/2004 Coll. – to perform the medical profes to issue the certificate for performing the medical profession abroad**

Pokyny k vyplnění žádosti

Confirming

**the basic qualification** to perform the medical profession:

◉ **Physician** ○ **Dentist** ○ **Pharmacist**

*Choose one of the options*

**Country for which the "Certificate" will be issued:** Choose country

*Check at least one of the options*

☑ a) that the basic qualification received in the Czech Republic is in accordance with the law of European Community and Directiv

☐ b) the specialist qualification in the field of _____, received in the Czech Republic, is in accordan European Communities and Directive of 2005/36/ES

☐ c) the length of basic medical training or performance of the medical profession in the Czech Republic

Personal data

| | |
|---|---|
| * Degree, Firstname, Lastname | MUDr., first Name, middle name, surname |
| Former surname | |
| * Birthday | (format: dd.mm.yyyy) |
| * Personal identification number | 0000000000 *Insert without slash* |
| * Place of birth | City and the country |
| * Citizenship | Choose country |
| Identification number | leav empty *Uvést v případě, že bylo identifikační číslo v informačním systému Ministerstva zdravotnictví vygenerováno* |
| Contact | Cell phone +420<br>E-mail<br>Phone +420 |
| Data box | ☐ *I am a private individual , individual entrepreneur or legal entity and I have data box available according to bill no. 300/2008 Sb. regarding electronic acts and authorized document conversion. Public authority will deliver the document in the data box, according to the nature of the document.* |
| * Address of permanent residence | Addressee MUDr. first Name middle name sur<br>Street h.n. č.or.<br>ZIP City City part<br>District<br>Country Choose country |

☐ Contact address **is different** than the address of permanent residence

ad a) the basic qualification

**Higher education:**

| | |
|---|---|
| * University | Charles University in Prague |
| * Faculty | 1st Faculty of Medicine |
| * Country | Česká republika |
| Program | General Medicine |
| * Field of qualification | General Medicine |
| * Diploma number | DL+10 digits number |
| * Issue date | last SE date (format: dd.mm.yyyy) |

Přílohy k žádosti

Declaration on the provision of personal data and the accuracy of those data

☑ **I agree** that for an unlimited period the Czech Republic - Ministry of Health, respectively its entrusting organisation, can use a information I have supplied for the purpose which is followed by this application and for the purpose of keeping a publicly avail medical health professionals. This all is in accordance with relevant provisions of the Act no. 101/2000 Coll., about privacy poli amendment of certain acts, as amended. I also agree that the information above may be provided or disclosed to the third par

☑ I proclaim that **all information** mentioned in the application **are correct, full and true**


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**Uložit a tisk**

^ Nahoru

* označuje povinný údaj

Uložit a tisk

Stránka vygenerována 6/9/2016 10:05:01 AM