Medical Certificate

Name of the patient:

…….. , …… ☐ m ♂ ☐ f ♀ ……

Last Name(s) First Name(s) gender DOB (dd/mm/yyyy)

The undersigned doctor, legally authorized to carry out his/her profession, having exercised physical examination on the above mentioned patient attests:

☐ There are no symptoms of any organic/infectious/contagious disease.

☐ The patient does not suffer any chronic disease (physical, phycological or psychiatric) that would constrict him/her physically or in any other way.

The patient has been diagnosed with COVID-19 with a positive test (PCR or antigen) in the last 90 days? ……. If this is the case, when was the test performed? :……

Has the patient been vaccinated against COVID-19? ……..

If so, which vaccine did he/she receive? ……

How many doses? ……..

When was the application date of the last dose? ……

Observations/diseases(physical, phycological or psychiatric)/allergies/comments/prescribed medication:

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……

Blood Type: ……

Rhesus Factor: ……

Stamp and/or professional license number:

Date: ……..

Doctor's name: ……

Doctor's signature: ……..

Professional license number: ……

Aviso de Privacidad:

La Dirección de Cooperación Académica de la Universidad Iberoamericana Ciudad de México, con domicilio en Prolongación Paseo de la Reforma número 880, Colonia Lomas de Santa Fe, Delegación Álvaro Obregón, Código Postal 01219, en la Ciudad de México, utilizará sus datos personales recabados para prestarle servicios académicos en la enseñanza de una lengua extranjera, y gestionar su trámite de movilidad académica. Para mayor información acerca del tratamiento y de los derechos que puede hacer valer, usted puede acceder al aviso de privacidad integral accediendo a la liga http://www.ibero.mx/aviso-legal-y-de-privacidad.