………………….., .. ……………….. ….

*place date*

**Request to the Supreme Medical Council (Naczelna Rada Lekarska)**

**for a certificate confirming completion in Poland of training meeting the requirements laid down in art. 34 of Directive 2005/36/EC and obtaining full Polish qualifications as a dentist with basic training**

…………………………………………………………………………..

*name of the applicant*

Sex: female ❒ male ❒

*The requested certificate is issued in electronic form (with electronic signature) and is sent by email as electronic document, unless the applicant requests the certificate to be issued and sent in paper version instead of the electronic form.*

Email address to send the electronic certificate:

………………………………………………………

I request the certificate to be issued in paper form instead of the electronic one ❒

Postal address to send the certificate

(to be indicated only if paper certificate is requested instead of the electronic form of the certificate):

………………………………

………………………………

………………………………

………………………………

I submit a request to the Supreme Medical Council (Naczelna Rada Lekarska) for issuance of a certificate confirming that under Polish law, as a holder of:

* dental diploma with the degree of ”lekarz dentysta” no. ………………. awarded by ……………………………………. on .. ……… ….,
* certificate confirming positive result of LDEK exam no. …………… awarded by Centrum Egzaminów Medycznych on .. …….… .…,
* decision of the Minister of Health recognizing the postgraduate internship no. ……………… rendered on .. ………. …. ,

I have obtained full Polish qualifications as a dentist in accordance with the Directive 2005/36/EC and in compliance with the training requirements laid down in art. 34 of Directive 2005/36/EC.

Hereby I declare that I do not hold a right to practice the profession of a dentist in Poland nor have I applied for that right.

………………………………..

 *signature*

 Attachments:

* diploma with the degree of ”lekarz dentysta” (version in Polish language) and diploma supplement,
* certificate confirming positive result of LDEK exam,
* decision of the Minister of Health recognizing the postgraduate internship,
* proof of payment of the fee.