Form No. 1

A Medical Clearance Form for the Doctor of Dental Surgery Program (International Program), Faculty of Dentistry, Mahidol University for Academic Year 2025

Part 1 Eligible Applicant Information **HN: .....**

Name: ..... Medical Examination Date: .....

Identification No. / Passport No.: ..... Application No.: .....

Address: .....

.....

Mobile No.: ..... E-mail: .....

Emergency contact: ..... Mobile No.: .....

To show the medical clearance results for admission to the Doctor of Dental Surgery Program (International Program), Faculty of Dentistry, Mahidol University for academic year 2025, I hereby certify that the above information is true.

I ..... hereby to confirm that now I do not have the following conditions.

- ☐ Psychosis
- ☐ Communicable diseases
- ☐ Non-communicable diseases
- ☐ Physical deformities.
- ☐ Hearing impairment
- ☐ Visual impairment
- ☐ Total color blindness
- ☐ Alcoholism
- ☐ Epilepsy
- ☐ Drug Addiction
- ☐ Leprosy
- ☐ Other illnesses or disabilities .....

Applicant's Signature.....

(.....)

Part 2 Physician Information

Name: ..... Medical Examination Date: .....

Medical License Code: .....

Hospital Address: .....

.....

Have taken a physical examination to Mr. / Miss.....

on..... with the results of the examination as follows.

Note: Misinformation and fraudulent examination will result in the cessation of students.

Form No. 2

A Medical Clearance Form for the Doctor of Dental Surgery Program (International Program),

Faculty of Dentistry, Mahidol University for Academic Year 2025

Name: ..... Medical Examination Date: .....

1.	Gender: ☐ Male ☐ Female			
2.	Eye exam*: Physician Signature ..... Code:			
	Vision: RE .....c glass .....c PH ...../ LE .....c glass ..... c PH			
	Color Blindness Test: Rt. eye: ☐ Normal ☐ Abnormal Lt. eye: ☐ Normal ☐ Abnormal	Please attach Ishihara and/or FARNSWORTH D 15 hue		
3.	Hearing: Turning fork test:			
	Air cond. > bone cond.		Rt. ☐ Normal ☐ Abnormal / Lt. ☐ Normal ☐ Abnormal	
	Weber's test lateralizing to		☐ Rt. ☐ Lt. ☐ Center	
4.	General appearance		☐ Normal ☐ Abnormal	
	4.1	HEENT	☐ Normal ☐ Abnormal	
	42	Superficial Lymph nodes	☐ Normal ☐ Abnormal	
	4.3	Respiratory system	☐ Normal ☐ Abnormal	
	4.4	CVS	☐ Normal ☐ Abnormal	
	4.5	Abdomen	☐ Normal ☐ Abnormal	
	4.6	Neurological system	☐ Normal ☐ Abnormal	
	4.7	Skin and musculoskeletal system	☐ Normal ☐ Abnormal	
	4.8	Mental health status	☐ Normal ☐ Abnormal	
5.	CXR*		☐ Normal ☐ Abnormal	
6.	โรคตับอักเสบ บี HBsAg*		☐ ไม่ติดเชื้อ (negative)	☐ ติดเชื้อ (positive)
	การมีภูมิคุ้มกัน Anti -HBs*		☐ มีภูมิป้องกัน	☐ ไม่มีภูมิป้องกัน
	โรคตับอักเสบ ซี Anti HCV*		☐ ไม่ติดเชื้อ (negative)	☐ ติดเชื้อ (positive)
	โรคอีสุกอีใส VZV antibody IgG*		☐ มีภูมิป้องกัน	☐ ไม่มีภูมิป้องกัน
7.	Audiometry		☐ PTA (AC) ≤ 25 dB	☐ PTA (AC) ≥ 25 dB
	Physician Signature ..... Code:			

Physician's conclusion of opinion and recommendations

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.....

Hospital Stamp

Physician's Signature .....

(.....)

Medical License Code .....

Hospital .....

Note: *Please attach the examination results: CXR (report and Film or CD), Blood exam, Eye exam, Audiogram and other)