



Personal data	Family name (previous family name in brackets, if any)	
	Given name(s)	Social security number and date of birth
	Citizenship	Native language
	Address	
	Postal code	City/town and country
	Telephone	E-mail address

I request that my degree in medical practice which I completed at _____
(name of medical school)

in _____ will be accepted in Finland as a degree in medicine leading to a doctor's profession.
(year of graduation)

Place and date of signature

Signature

Sign and mail this form and appendices to: Valvira, The National Supervisory Authority for Welfare and Health
P.O. Box 210
FI-00281 Helsinki, Finland