DECLARATION

The undersigned:

_____

from city (village) _____, Municipality _____, District _____

Str ._____ № _____, bl ._____, entr ._____, ap. _____

PIN _____ ID card № _____

date of issue _____issued by _____

I declare that:

1. I provide to the Medical University "Prof. Dr. Paraskev Iv. Stoyanov ”- Varna my personal data voluntarily in connection with my participation in the procedure for recognition of higher education acquired at a foreign higher education institution, initiated at my request.

2. I am informed that the processing of my personal data is necessary for the fulfillment of statutory obligations of Medical University "Prof. Dr. Paraskev Iv. Stoyanov ”- Varna and is a necessary condition for conducting and completing the procedure for recognition of higher education acquired by me at a foreign higher education institution.

3. I am informed that Medical University - Varna will process my personal data in accordance with the result of the conclusion of the procedure (recognition or non-recognition of my higher education), regulatory requirements and relevant internal rules and regulations of the university.

Date: _____ DECLARATOR: _____

/ signature /