

**UNIVERSITY OF MALTA
INSTITUTE OF HEALTH CARE
Division of Radiography Studies**

ERASMUS Student Exchange

REGISTRATION FORM

Surname: _____

Name: _____

Address: _____

Postcode: _____

Telephone No.: _____

E-mail Address: _____

Date of Birth: _____

Nationality: _____

Passport No.: _____

Name and address of educational institution:

**Details of contact person in case of emergency:
(Name, address and telephone no.)**

Signature _____

Date _____