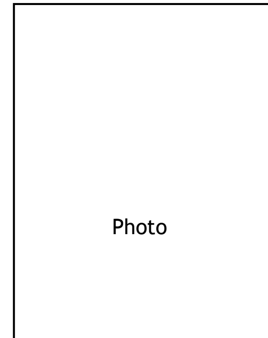
UNIVERSITY OF MALTA
FACULTY OF HEALTH SCIENCES
Department of Radiography

Student Exchange
ERASMUS / ELECTIVE

REGISTRATION FORM
ACADEMIC YEAR 20_ _/20_ _



Surname: ____________________________

Name: ____________________________

Address: _______________________________________

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Postcode: ________________

Telephone No.: __________________________________

Mobile No.: (+)__________________________

E-mail address: __________________________________

Date of Birth: __________________________________

Nationality: ____________________________

Passport No.: ____________________________

Proposed dates of stay in Malta:

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Name and address of educational institution (home university):

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Postcode: ________________

Details of contact person in case of emergency:

Name: ____

Address: ____

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Tel. No.: _____________________

Mob. No.: _____________________

Signature: ___________________________ **Date:** _______________________