



Attach recent
photograph

SOCRATES/ERASMUS MOBILITY EXCHANGE – L-UNIVERSITA' TA' MALTA
ACADEMIC YEAR 20__ /20__
STUDENT ENROLMENT FORM

Kindly fill application in Block letters in BLACK

PERSONAL DATA (please write legibly)

Last Name: _____	First Name: _____
Date of Birth: _____	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
Marital Status: Single <input type="checkbox"/> Married <input type="checkbox"/>	
Nationality: _____	Passport No: _____ Valid Till: _____
Home address: _____ _____	
Tel: _____	Mobile Phone No: _____ Fax: _____
E-mail address: _____	

LANGUAGE COMPETENCE

Mother tongue: _____	Language of instruction at home institution (if different): _____		
English language:	I am currently studying this language	I have sufficient knowledge to follow lectures	I need additional linguistic preparation to follow lectures
	YES NO	YES NO	YES NO
	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/>

CURRENT STUDY

Home University/Institution _____
Faculty: _____ Course: _____
Course Duration: _____ Course Years: _____ Year of Study: _____
Areas of study in Malta: _____
Would you like to spend the <input type="checkbox"/> 1 st or <input type="checkbox"/> 2 nd semester in Malta?

In the space below tell us more about yourself so that we may have a clear picture of you as a person and as a prospective University of Malta student. For example you might want to tell us about your future goals, your interests and/or your cultural background: _____

PARTICULAR REQUESTS

Kindly include any medical information which is important for us to know during your stay in Malta:

Kindly attach a transcript of records for study-programme already followed.

Signature: _____

Date: _____

The following will be filled in by the University of Malta

RECEIVING INSTITUTION

UNIVERSITY OF MALTA, MSIDA MSD 06, MALTA

Tel: (+356) 2340 2204 Fax: (+356) 21 323807

Institutional Co-ordinator: Dr. Joseph Mifsud, Director European Unit

Tel: (+356) 2340 2204 Fax: (+356) 21323807 E-mail: Erasmus@um.edu.mt

Departmental Co-ordinator: _____

Tel: _____ Fax: _____ E-mail: _____

We hereby acknowledge receipt of the application, the proposed learning agreement and the candidate's transcript of records.

The proposed student has been accepted at our institution for a period of months between _____

not been accepted at our institution. Specify reason: _____

Departmental Co-ordinator's signature

Institutional Co-ordinator's signature

Date: _____

Date: _____

NB: Students' acceptance is conditional to the receipt of all the required forms (Enrolment Form, Health Form, Important Information Form). Acceptance is also subject to the approval by the European Unit.