



Late Application for Registration for Continuing Professional Development Study-Units
Academic Year 2019-20

Application No:

Section A: LATE APPLICATION FOR STUDY-UNITS OFFERED DURING ACADEMIC YEAR 2019-20

Tick one box from 1st preference and one box from 2nd preference

1 st pref.	2 nd pref.	Code	Study-Unit Title	Semester
		MID4012	Perineal Care and Repair for Midwives	Semester 1
		MNH4002	Rights and Responsibilities in Mental Health Care	Semester 1
		POD5001	Vascular Assessment of the Lower Extremities	Year

Data Privacy Policy

The data below is requested in view of your application for admission to the University of Malta. This data will be processed strictly in accordance with the provisions of the General Data Protection Regulation (GDPR) and all other applicable privacy and data protection legislation. To learn more about your rights and the University's processing of your personal data, please visit: <https://www.um.edu.mt/registrar/students/dataprivacystatement>.

Section B: PERSONAL DETAILS (USE BLOCK LETTERS)

I.D. Card No. _____

Gender: Male Female

Surname*: _____

Name*: _____

Maiden Surname: _____

Date of Birth: __/__/__ Age: _____
dd mm yyyy

Post: _____

Present Place of Work: _____

Ward/Area: _____

Nationality: (1) _____

(2) _____

Address:

House No.: _____

Home Tel. No.: _____

Street: _____

Work Tel. No.: _____

Town: _____

Mobile No.: _____

Postcode: _____

Email Address: _____

Country: _____

* This is the name that will appear on your transcript of results.

Section C: NEXT OF KIN

Relationship to Applicant: _____

Surname: _____ Name: _____

Address: Same as Applicant? Yes No

If No, please specify:

_____ Postcode: _____

Telephone/Mobile No.: _____

Section D: DISABLED APPLICANTS/MEDICAL CONDITION

This information is being requested for the University to provide you with appropriate help and services to facilitate your studies.

Do you have any disability that the University of Malta should be aware of?

Tick as appropriate

Yes No

If yes, please specify:

Hearing Impairment	<input type="checkbox"/>
Mobility Impairment	<input type="checkbox"/>
Specific Learning Difficulty	<input type="checkbox"/>
Visual Impairment	<input type="checkbox"/>

Other _____

It is in your interest to inform the University of a disability or long term medical condition. This information will be used to enable the University to provide you with appropriate help and services to facilitate your studies. Should anything change during your studies, please inform us.

Section E: ADDITIONAL INFORMATION

- Only **one** application should be submitted.
- Applicants are to submit the certificate of registration/enrolment for verification purposes.

Late application forms must be handed in personally to Ms Kelly Grech, Room 28, Faculty of Health Sciences, Block A, Level 1, Mater Dei Hospital between **Monday 22 July and Wednesday 24 July 2019 from 8.00am to 1.00pm.**

Section F: STATEMENT OF INTEGRITY
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It is important to read carefully the statement below before ticking the box.

I declare that the information given is **correct and complete** at the time of submission of this application. I bind myself to produce original certificates by the date indicated to me. The University of Malta reserves the right to withdraw or amend any offer made or terminate any subsequent registration should the information given in the application be found to be incorrect.

Integrity Approval

I have read and agree with the above statement

Applicant's Signature

Date