



**Late Application for Registration for Continuing Professional Development Study-Units  
Academic Year 2018-19**

Application No: \_\_\_\_\_

**Section A: LATE APPLICATION FOR STUDY-UNITS OFFERED DURING ACADEMIC YEAR 2018-19**

Tick one box from 1<sup>st</sup> preference and one box from 2<sup>nd</sup> preference

| 1 <sup>st</sup> pref. | 2 <sup>nd</sup> pref. | Code    | Study-Unit Title                        | Semester   |
|-----------------------|-----------------------|---------|---|------------|
|                       |                       | MNH4001 | Child and Adolescent Mental Health      | Semester 2 |
|                       |                       | NUR2533 | First Aid for Health Care Professionals | Semester 1 |
|                       |                       | NUR5119 | Patient Safety in Health Care Practice  | Semester 2 |

**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.

Application forms must be handed in personally to Ms Kelly Grech, Room 30, Faculty of Health Sciences, Block A, Level 1, Mater Dei Hospital between **Wednesday 18<sup>th</sup> July and Friday 20<sup>th</sup> July 2018, from 8.00am to 1.00pm.**

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| <b>Section F: STATEMENT OF INTEGRITY</b> |
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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