L-Università ta' Malta
Faculty of Medicine & Surgery

MMSA
ELECTIVES

F. HOME UNIVERSITY RECOMMENDATION

To be completed by the Dean or Designate of the Home University – Please fill in all the required details.

I certify that ____ is a registered student at the ____ (Name of Medical School) currently in the _____ year of a _____- year programme leading to a MD Degree. At the time of the proposed elective, student will be in the _____ year of academic study. (Please circle) **He / She** is expected to graduate in _________________________(month/ year).

I confirm that the above-named medical student is in good standing with this Medical School, and I support without reservation (please circle) **his / her** request to take part in the Elective Programme at the University of Malta. Our university has authorised this student to undertake this elective.

I (please circle) **am / am not** aware of any past, current or pending cases of discipline or convictions of any nature whatsoever in relation to this student.

I (please circle) **am / am not** aware of any medical condition of the student. If aware, please specify: ______________________________.

I certify that the photograph attached on Page 1 of this form (please circle) **is / is not** a true likeness of the applicant.

The student (please circle) **is / is not** covered by medical malpractice insurance by this university during the Medical Elective Placement in Malta.

Signature: __________________________________ Date: _________________________________

Name & Surname: ___________________________ Title: _________________________________

E-mail address: _____________________________ Telephone: +___________________________

Official Stamp of Medical School: