APPLICATION FORM

Master of Science degree in collaboration with RCSI, in Health Research

PERSONAL INFORMATION

Name: (Dr/Mr/Ms)

(Please underline surname)

Sex: □ Male    □ Female    NRIC / Passport No: ______________________

Date of Birth: ____________________ Place of Birth: ____________________

Citizenship: ____________________ Marital Status: ____________________

Home Address:
________________________________________
________________________________________
________________________________________

Work Address:
________________________________________
________________________________________
________________________________________

Postcode: ________ Postcode: ________

Tel No.: ____________________ H/P No: ____________________

Email: ____________________

EDUCATIONAL BACKGROUND

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<th>School / College / University Attended</th>
<th>Name of Qualifications</th>
<th>Year Enrolled</th>
<th>Year Completed</th>
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Please give details for any additional Qualifications & Training:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
ENGLISH PROFICIENCY

GCE“O” Level /119 /English  Grade: ________________  Date of test: ________________

MUET  Grade: ________________  Date of test: ________________

IELTS  Overall Score: ________________  Date of test: ________________

Please give details of any alternative English Proficiency Test or English Education undertaken:
__________________________________________________________________________________
__________________________________________________________________________________

WORK EXPERIENCE

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<th>Years of service</th>
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Please give details for any additional Experience, Professional Accomplishments & Training:
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

I hereby verify that all the information given in this application is correct.

Applicant’s Signature: ___________________________________________  Date: ______________

CHECKLIST

Application Procedure: This form should be completed and returned to:
Postgraduate Admissions, Penang Medical College, 4 Jalan Sepoy Lines, 10450 Penang.
OR e-mailed to: postgraduate@pmc.edu.my

The following should be enclosed:

☐ Examination records & certificates by school authorities and full transcript of any University Studies.

☐ Certified copy of Birth Certificate and MyKad (Malaysian) or Passport Cover Page (International)

☐ Two recent passport-size photographs with your name written on the back

☐ Confidential Referral Letter by a superior or head of department (as proof of character)