APPLICATION FORM

University College Dublin (UCD) Master of Science degree in Public Health

PERSONAL INFORMATION

Name: (Dr/Mr/Ms) ____________________________________________________________

(Please underline surname)

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

Date of Birth: _____________________  Place of Birth: __________________________

Citizenship: ______________________

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>Employer</th>
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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:
Admissions, Penang Medical College, 4 Jalan Sepoy Lines, 10450 Penang.
OR e-mailed to:
admission@pmc.edu.my
Lavaniah K: lavaniah@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 (Snail Mail Applicants) / Scanned image (Online Applicants)
☐ Confidential Referral Letter by a superior or head of department (as proof of character)