UNIVERSITY OF GHANA SCHOOL OF MEDICINE AND DENTISTRY
COLLEGE OF HEALTH SCIENCES
ACADEMIC AFFAIRS OFFICE
ELECTIVES APPLICATION FORM

1. SURNAME (Block Letters)……

2. FORENAME (Block Letters)……

3. HOME ADDRESS……..

4. DATE OF BIRTH …….. 5. SEX ……

5. NATIONALITY……

6. NAME & ADDRESS OF UNIVERSITY ……

7. NAME & ADDRESS OF MEDICAL SCHOOL ……

8. DATE OF ADMISSION INTO MEDICAL SCHOOL ……

9. DATE YOU EXPECT TO COMPLETE YOUR MEDICAL COURSE AND GRADUATE: ……..

10. PRESENT YEAR OF STUDY (ie. 3rd, 4th & 5th) ……..

11. COURSES TAKEN LAST ACADEMIC YEAR WITH DATES ……..

    ……

12. COURSES CURRENTLY BEING TAKEN ……..

13. EXAMINATION(S) PASSED SO FAR ……..

    ……

14. SUBJECT(S) YOU WISH TO STUDY AT SCHOOL OF MEDICINE AND DENTISTRY WITH DATES:

    1ST CHOICE ……(Dates) From…… To ……..Year……

    2ND CHOICE……

    3RD CHOICE……

15. PLEASE STATE WHETHER THIS ELECTIVE IS A REQUIREMENT FOR YOUR GRADUATION: ……

16. DO YOU REQUIRE AN OFFICIAL REPORT ON COMPLETION OF ELECTIVES? ……..

17. DO YOU REQUIRE ACCOMMODATION? ……..

18. HAS YOUR DEAN SENT A SUPPORTING LETTER? .....

19. LANGUAGES SPOKEN AND WRITTEN (In order of proficiency (i) ..... (ii) .....

20. E-MAIL ADDRESS: .....

Please attach a passport size photograph to the Application Form

Post picture here

THANK YOU.

SCHOOL ADMINISTRATOR