

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

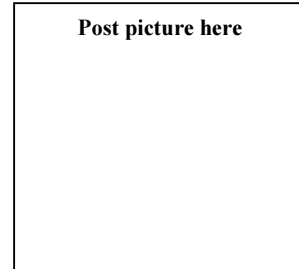
1. SURNAME (Block Letters).....
2. FORENAME (Block Letters).....
3. HOME ADDRESS.....
4. DATE OF BIRTH ..... 5. SEX .....
5. NATIONALITY.....
6. NAME & ADDRESS OF UNIVERSITY .....
7. NAME & ADDRESS OF MEDICAL SCHOOL .....
8. DATE OF ADMISSION INTO MEDICAL SCHOOL .....
9. DATE YOU EXPECT TO COMPLETE YOUR MEDICAL COURSE AND GRADUATE: .....
10. PRESENT YEAR OF STUDY (ie. 3<sup>rd</sup>, 4<sup>th</sup> & 5<sup>th</sup>) .....
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:  
1<sup>ST</sup> CHOICE .....(Dates) From..... To .....Year.....  
2<sup>ND</sup> CHOICE.....  
3<sup>RD</sup> 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**



THANK YOU.

SCHOOL ADMINISTRATOR