UNIVERSITY OF THE WESTERN CAPE
FACULTY OF DENTISTRY
INTERNATIONAL ELECTIVE PROGRAMME

Application for elective visits by foreign students

TITLE	SURNAME	INITIALS	DATE OF BIRTH (DD/MM/YYYY)

BIOLOGRAPHICAL DETAILS

Surname | Initials | Title | First Name

Date of Birth | Gender

Birth Country

Home Language

Mobile Number | Email Address

Postal Address | Home Address

English Proficiency | YES | NO

Passport / ID Number

A. ELECTIVE PLACEMENT REQUEST

Which discipline(s) are you interested in? Discipline 1:

Discipline 2:

REQUESTED PERIOD:

Start Date | End Date

B. EMERGENCY CONTACT DETAILS (NEXT OF KIN)

Surname | Initials | Title

Relationship

Mobile Number

Email Address

C. APPROVAL BY YOUR UNIVERSITY (TO BE COMPLETED BY HOME INSTITUTION)

I confirm that (name of student) _____ is a full time student in good standing at this University

University

Address

Name of Degree

Year of Study

Signature

Title

Date

University Stamp

D. MOTIVATON FOR VISIT

Signed by Student

Date