

APPLICATION FORM

The undersigned (name) _____ (surname) _____
Place of birth _____ Date of birth ____/____/_____
Tax Code _____
Nationality _____ living in _____ Postcode _____ (Prov. _____)
Address (Street) _____ (Number) _____
Telephone _____ Mobile _____
E-mail address*: _____

wishes to apply for the UniCamillus Medicine and Surgery, Dentistry, and Health Professions Summer School which will take place from Monday 1 July 2024 to Friday 5 July 2024.

The undersigned **declares**, pursuant to Legislative Decree no. 445/2000 and subsequent amendments and additions, aware of sanctions in the event of false statements or use of false acts under his/her own responsibility, that:

- ✓ he/she has a high school diploma/is enrolled in one of the last two years of high school
- ✓ he/she has paid the registration fee of €1050,00 (standard package), or
- ✓ he/she has paid the registration fee of €1350.00 (accommodation package)
- ✓ he/she is aware that the University reserves the right to change dates, times and teaching mode of courses (participants will be notified well in advance) and will not run the course if the number of participants is less than 30. Please note that applications, including payment, must be received by 13:00 on Wednesday 2 May. Applications submitted after the maximum number of participants has been reached will not be considered and the amount will be refunded.

BENEFICIARY: Saint Camillus International University of Health and Medical Sciences – UniCamillus

IBAN: IT17 T056 9603 2000 0001 3317 X38 (Banca Popolare di Sondrio)

REASON FOR PAYMENT: (*indicate name and surname of applicant + Summer School)

The undersigned is submitting (unilife@unicamillus.org) attached to this application form:

- ✓ A copy of a valid ID document, signed on both sides;
- ✓ Information pursuant to national and EU legislation on the protection of personal data
- ✓ Receipt of the paid registration fee

(Date)

(Full legible signature)