American Medical Academy

Application Form

Name: _____ **Date of Birth:** _____
Last First Middle dd/mm/year

Sex: ☐Male ☐Female **Marital Status:** ☐Single ☐Married

Citizenship: _____ **Placeof Birth:** _____
City/Country

Passport#: _____ **Date Issued:** _____ **Place Issued:** _____

Home Address:

_____
Street Box/Apt.# City Country Zip Code

( ) **( )** _____
Telephone Number Mobile Number Email Address

Mailing Address (if different):

_____
StreetBox/Apt.# City Country Zip Code

( ) _____
Telephone Number Email Address

Emergency Contact Information:

Name: _____
Last First Middle

Relationship to applicant: _____

Address:

_____
Street Box/Apt. # City Country Zip Code

( ) @ _____
Telephone Number Email Address

Educational Background: (if additional room is needed, please attach a separate sheet)

You must attach an official copy of transcripts from all schools attended as well as your school leaving diploma or certificate

Please list all secondary schools you have attended:

Name of Institution	Years Attended	Date of Graduation	Diploma Number	Date Diploma Issued	Type of Degree/Diploma Received

Please list all colleges and/or universities you have attended:

Name of Institution	Years Attended	Degree/Diploma Received

Please list all languages you speak and your level of knowledge:

Language	Degree of Knowledge (Beginner, Intermediate, Advanced)

General Information

All applicants are required to provide a current CV and copy of your passport.

I certify that I have completed this application myself and without assistance; the information given in this application is complete and accurate.

I understand that the American Medical Academy Inc., reserves the right to verify all the information listed in the application. I understand that giving false or misleading information in the application will result in exclusion from the completion of theprogram.

SignatureofApplicant Date