

AMERICAN MEDICAL ACADEMY INC.

AMA POLAND Z.O.O. - MEDICAL CAMPUS

Initial Application for Clinical Training & Medical License



Name: Date of Birth:

Last First Middle dd/mm/year

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

Citizenship: Place of Birth:

City/Country

Passport#: Date Issued: Place Issued:

Home Address:

Street Box/Apt.# City Country Zip Code

( ) ( )

Telephone Number Mobile Number Email Address

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| --- | --- | --- | --- |
| **Mailing Address (if different):** |  | | |
| Street Box/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 |
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**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) |
|  |  |
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**General Information**

All applicants are required to provide a short CV, a copy of their passport, and a copy of his/her academic transcripts for admission consideration.

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., and AMA Poland z.o.o. 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 the program.

Signature of Applicant Date