



UNIVERSIDADE CATOLICA TIMORENSE

DILI, TIMOR LESTE

APPLICATION FORM FOR MEDICINE (MBBS)

ADMISSION NO:

ADMISSION DATE:

<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
D	D	M	M	Y	Y	Y	Y

ACADEMIC YEAR 20__-20__

Photograph

REFERRED BY: _____

APPLICANT INFORMATION IN BLOCK LETTERS

Surname			
Given Name			
Middle name			
Gender	<input type="checkbox"/> Male	<input type="checkbox"/> Female	other
Place of Issue	Nationality	Date of Birth	
Expiry Date			

FAMILY DATA

Father's Name	Occupation
Mother's Name	Occupation

ADDRESS

Permanent Home Address	Tel. No.
	Mobile No.
	Alt No.
	Email
Correspondence Address	Tel. No.
	Mobile No.
	Alt. No.
Local Guardian's Name (if any)	Email
Address	
Contact No.	

Have you written NEET? Yes No

If yes, NEET Result Year: _____ NEET Score: _____ Community: _____

ACADEMIC ACHIEVEMENT

10TH Standard

Name of Institution: _____

Board affiliated to: _____

S.No	SUBJECTS	MARKS (%)	YEAR OF PASSING
1			
2			
3			
4			
5			
6			

12TH Standard

Name of Institution: _____

Board affiliated to: _____

S.No	SUBJECTS	MARKS (%)	YEAR OF PASSING
1			
2			
3			
4			
5			
6			

CONFIRMATION

I, the undersigned confirm that to the best of my knowledge, the information furnished in this APPLICATION FORM is true and complete.

I agree to all the Terms and Conditions listed in this Application Form.

Applicant's Signature

Date

Parent's / Gaurdian's Signature