APPLICATION FORM

11th EUROPEAN BOARD OF NEUROLOGY EXAMINATION

Oslo, 28 giugno 2019

DA RESTITUIRE A SEGRETERIA SIN INFO@NEURO.IT ENTRO 10 FEBBRAIO 2019

PERSONAL DATA

Mr. Ms.

Title:

First Name:*

Family Name:*

Institution:

Department:

Street:*

ZIP:

City:*

Country:* Please select...

Phone:*

E-mail:*

Please note that all further correspondence will be addressed to this email. Please make sure to provide us with a correct address.

Date of Birth:*

Passport Number:*

Nationality:*

* Required fields

NEUROLOGICAL TRAINING

(Scheduled) End of Training:*

and/or

Date of Certification as Neurologist*:

*Candidates, who have not yet been certified should enter a provisional (future) date

Certifying Institution:*

Country of Certification:*

Please list the institutions where you have been trained according to your national curriculum in neurology:*

	Institution	Start of Training (MM/YYYY)	End of Training (MM/YYYY)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			