



APPLICATION FORM
12th EUROPEAN BOARD OF NEUROLOGY EXAMINATION
Parigi, 22 maggio 2020

DA RESTITUIRE A SEGRETERIA SIN INFO@NEURO.IT ENTRO 10 FEBBRAIO 2020

PERSONAL DATA

Mr. Ms. Title: _____

First Name:* _____ Family Name:* _____

Institution: _____ Department: _____

Street:* _____ ZIP: _____

City:* _____ Country:*

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.	_____	_____	_____