

MEDICAL FACULTY

**FOREIGN STUDENTS DEPARTMENT**

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Academic year 20...../20.....

Course.....

Faculty number.....

Group.....

**REGISTRATION FORM**

1. Name.....
2. Country.....
3. Degree Programme.....
4. Address in Sofia.....
5. Telephone/e-mail.....
6. Date and place of birth.....
7. Passport (passport №, date of issue, issuing authority, period of validity).....  
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8. Number of the Bulgarian Residence Permit.....
9. Permanent Address (country, city, street).....
10. Nationality.....
11. Secondary Education (name of the school, graduation year).....  
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Sofia.....20.....

Signature.....