

Applicant No. (Do not write)

**Application of admission to Graduate School of Medicine,  
Kansai Medical University (2018 Academic Year)**

Preferred field of research	Medical Science Course					
	Subject					
	Supervising professor※	seal				
Name				Permanent Address	Prefecture or Nationality	<p align="center"><b>Photo</b> (5cm×4cm)</p> <p>Taken within three months</p> <p>Fill out your name and university on the backside</p> <p>Paste total area</p>
English name						
Date of birth	year	month	day (Age )	Sex	Male · Female	
Contact address	(〒 - )					
	TEL		Cell-phone			
	e-mail					
Place of work	(Name)					
	(〒 - )					
	TEL	(extension )				
Qualification for admission	University	year month day			Graduated · Will graduate	
	Graduate School	year month day			Completed · Will complete	
Guarantor	Name			Relation to the applicant		
	English name			Occupation		
	Current address	(〒 - )	TEL			

※In case that the applicant doesn't have a supervising professor in the research institute, belonging to the university, please write a name of professor or associate professor.

I hereby apply for admission to Graduate School of Medicine, Kansai Medical University with specified documents.

Date            year            month            day

Name

**To the president of Kansai Medical University**

Resume					
Category	Month	Year	Events (after entering high school)		
Education			Entered High School		
			Graduated from High School		
			Entered Department of ,Faculty of , University		
			Graduated from Department of ,Faculty of , University		
			Entered Graduate School of , University		
			Graduated from Graduate School of , University		
Job Career					
Awards & Penalties					
Medical License	Passed Year		License Number		
	The    th. Examination	No.			
	Month    Year				
Postgraduate Clinical Training	Name of Hospital		Term	Completed	
			From    (Month)    (Year)	Will Complete	
					Not Complete
					To       (Month)    (Year)

Family	Relation	Name	Occupation	Relation	Name	Occupation
	Father					
	Mother					