(Form A-1)

Applicant No. (Do not write)

Application Form for the Doctoral Program, Graduate School of Medicine, Kansai Medical University (April 2027 Admission)

Preferred research field	Division of Medicine				
	Research field				
	Supervising professor	(Name) (Signature or seal)			
Applicant's information					
Name	Surname		Gender		Photo (4cm×3cm) Taken within the last 3 months prior to application date. Write your name on the backside. Refer to the following URL for other requirements. https://www.isa.go.jp/en/applications/guide/photo_info.html
	Given name		Nationality		
	Middle name		Marital Status	Single / Married	
Date of birth	Year Month Date (Age)				
Contact address	Postal code				
	Address				
	Home phone		Mobile phone		
	E-mail				
Place of work	Name				
	Postal code				
	Address				
	Phone	(extension)			
Past entry into / departure from Japan	Number of times		Period *List from your most recent visits.	(From) yyyy/mm/dd ～ (To) yyyy/mm/dd (Purpose)	
				(From) yyyy/mm/dd ～ (To) yyyy/mm/dd (Purpose)	
Application eligibility	Place check boxes that apply to you by referring to the sheet "Doctoral Program Application Eligibility".				
	I meet the following requirements (1) ☐ (2) ☐				
Emergency contact in home country	Name				
	Relationship with the applicant		Occupation		
	Postal code				
	Home address				
	Phone		E-mail		

I hereby apply for the Doctoral Program, Graduate School of Medicine, Kansai Medical University with specified documents.

Year Month Date

Name
(Signature)

To the president of Kansai Medical University

(Form A-2)

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

Total period of education (from elementary school to last institution of education)		Years

Job Career			
Awards & Penalties			

Medical Qualifications	Yes / No	Qualification date (Year / Month)	
		License Number *If you have a medical license.	No.

Postgraduate Clinical Training	Name of Hospital	Term
		From (Year) (Month) To (Year) (Month)

Questionnaire

*Check the appropriate box as it will be required for immigration procedures, if you pass the examination.

Accompanying persons, if any (such as your family)	☐	Yes	☐	No
Past history of applying for a certificate of eligibility	☐	Yes	☐	No
Criminal record (in Japan / overseas) *Including dispositions due to traffic violations, etc.	☐	Yes	☐	No
Departure by deportation / departure order	☐	Yes	☐	No
Family in Japan and cohabitants	☐	Yes	☐	No