Doctorate in Pharmacy (Pharm.D.) Thesis Form

Department of Pharmacy, Faculty of Medicine and Surgery, University of Malta
in collaboration with the College of Pharmacy, University of Illinois, Chicago, USA

Section A	
Last Name:	**First Name:**
Maiden Last Name *(if applicable)*:	**Gender**: ☐ **Male** ☐ **Female**
Identity Card Number:	**Nationality:**
Date of Birth:	**Age:**
Address:	
Telephone:	**Mobile:**
Email:	

Section B *(to be filled by applicant in consultation with the proposed supervisor)*
Name of member of staff who has agreed to act as supervisor:
Name of member of staff who has agreed to act as co-supervisor:
Proposed title of thesis: ***Kindly attach a detailed research proposal on separate sheets***

Please confirm that this thesis has/has not been submitted for another postgraduate degree or independently published before in full/in part
I declare that the information given is correct and complete. I am aware that the application will not be considered if incorrect or incomplete information is given. **Signature: _____ Date: _____**

Section C
Statement by Proposed Supervisor: **Signature: _____ Date: _____**
Statement by Head of Department: **Signature: _____ Date: _____**