QUEEN’S UNIVERSITY, BELFAST

SCHOOL OF MEDICINE, DENTISTRY & BIOMEDICAL SCIENCES

# **APPLICATION FOR AN INTERCALATED DEGREE - (2026/2027)**

NAME [IN FULL]: ....................................................................................................................................... [Block Capitals]

HOME ADDRESS: ..........................................................................................................................................................

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TELEPHONE NO: .............................................................. E:MAIL: ..............................................................

STUDENT NO: ............................................................... YEAR OF STUDY: .............................................

UNDERGRADUATE STUDENT IN: MEDICINE / DENTISTRY [please delete as appropriate]

|  |  |  |
| --- | --- | --- |
| Name: | Full Address: | |
| **DEGREE PATHWAY:** | | |
| **TITLE OF RESEARCH PROJECT**  1st choice:  2nd choice: | | **SUPERVISOR(S):** |

STUDENT SIGNATURE: ............................................................................................... DATE: ......................................

COURSE CO-ORDINATOR SIGNATURE: .................................................................... DATE: ......................................

PLEASE RETURN YOUR FORM TO THE INTERCALATED DEGREE COURSE CO-ORDINATOR (details in handbook).

### CLOSING DATE FOR RECEIPT OF APPLICATIONS:

### *FRIDAY 24TH APRIL 2026*