QUEEN’S UNIVERSITY, BELFAST

SCHOOL OF MEDICINE, DENTISTRY & BIOMEDICAL SCIENCES

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

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

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

 ..........................................................................................................................................................

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*