



# APPLICATIONS FORM for PARTICIPATION

MASTER of SCIENCE in  
PRENATAL DIAGNOSIS DELIVERY CONTRACEPTION  
SCHOOL of HEALTH SCIENCES, SCHOOL of MEDICINE DEMOCRITUS  
UNIVERSITY OF THRACE ACADEMIC YEAR 2024-2025

## Personal information

Last name: \_\_\_\_\_  
First name: \_\_\_\_\_  
Name of father: \_\_\_\_\_  
Home address: \_\_\_\_\_  
Zip code: \_\_\_\_\_  
Country: \_\_\_\_\_

Recent Photo

## Contact Numbers

Home telephone number: \_\_\_\_\_  
Work telephone number: \_\_\_\_\_  
Mobile: \_\_\_\_\_  
e-mail: \_\_\_\_\_

I am attaching the supporting documents  
required for my participation in master of  
science

«[Prenatal Diagnosis Delivery Contraception](#)»

Date of birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Place of birth: \_\_\_\_\_  
Personal Identity Card: \_\_\_\_\_  
Tax Identification Number: \_\_\_\_\_  
Public financial services, tax office: \_\_\_\_\_  
Marital status: Married ☐ Single ☐ Divorced ☐  
Property – Profession: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_ / \_\_ / 20 \_\_

## Attached Documents:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_

1. I hereby declare responsibly that I have been informed about the Internal Operating Regulations of the Postgraduate Course ([Official Government Gazette#1](#), [Official Government Gazette#2](#) and [Official Government Gazette#3](#)) and I agree.
2. Tuition fees will be paid no later than the day of the start of each semester in accordance with the procedures to be announced.

All supporting documents should be submitted to the Post Graduate Course Prenatal Diagnosis Delivery contraception Secretariat by the deadline for submission of applications .../.../2024:

Secretarial Support: Mrs. Maria Tasteridou  
University General Hospital of Alexandroupolis, 2nd floor  
68100 Alexandroupolis  
Tel. +30 2551353157

e-mail: [prenataldiagnosis-labor@med.duth.gr](mailto:prenataldiagnosis-labor@med.duth.gr)

MASTER of SCIENCE  
in PRENATAL DIAGNOSIS DELIVERY CONTRACEPTION  
UNIVERSITY GENERAL HOSPITAL of ALEXANDROUPOLIS  
DRAGANA, 68131 ALEXANDROUPOLIS  
TEL : (+30) 2551353157

E-mail: [prenataldiagnosis-labor@med.duth.gr](mailto:prenataldiagnosis-labor@med.duth.gr)