



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 2025-2026

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: __ / __ / 2025

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 email address prenataldiagnosis-labor@med.duth.gr

The period for submission of applications is **from October 10, 2025 until December 31, 2025**

For more information please contact with the Secretarial Support Mrs. Maria Tasteridou

University General Hospital of Alexandroupolis, 2nd floor

68100 Alexandroupolis

Tel. +30 2551353157

e-mail: 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