



**ISRAEL GOVERNMENT SCHOLARSHIPS (Academic year: 20\_\_ – 20\_\_)**

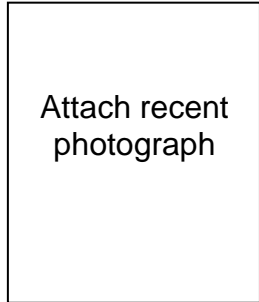
**APPLICATION FORM**

**To be filled out, in English, in triplicate**

**Country of origin:** \_\_\_\_\_

**Scholarship required:**

1. Short term Scholarship: Language Summer Course (Ulpan)
2. Long term Scholarship (One Academic Year = 8 months only):  
Post Doctorate/ Research /Ph.D / M.A. / Overseas program



1. Surname: \_\_\_\_\_
2. First name: \_\_\_\_\_
3. Place of birth: \_\_\_\_\_
4. Citizenship: \_\_\_\_\_
5. Date of birth: \_\_\_\_\_
6. Gender: Male / Female
7. Permanent address: \_\_\_\_\_  
\_\_\_\_\_
8. Passport no.: \_\_\_\_\_
9. Telephone: \_\_\_\_\_ Cellular Phone: \_\_\_\_\_
10. Fax: \_\_\_\_\_
11. E-mail: \_\_\_\_\_
12. Marital status: \_\_\_\_\_
13. At which institution do you wish to pursue your studies or undertake research work?
  - A. \_\_\_\_\_
  - B. \_\_\_\_\_
  - C. \_\_\_\_\_

14. Do you have a supervisor already? (for post doctorate and research students only)

YES                      Name of supervisor \_\_\_\_\_

(If yes, please enclose any letter you have from your supervisor.)

NO

15. Have you been in contact, or have you registered to any university or professor in Israel?

(Please indicate.)

\_\_\_\_\_

16. Have you been accepted by any university or professor in Israel? (Indicate and enclose a letter of acceptance).

\_\_\_\_\_

17. Current and Previous University Education:

List in chronological order, starting with your current enrollment, all colleges and universities you have attended.

Name and Place of Institution	Major	No. of Years	Date of Graduation	Degree

18. In which language will you conduct your research/studies in Israel? \_\_\_\_\_

19. Language Skills: (x – none ; xx – poor ; xxx – fair ; xxxx – good ; xxxxx – fluent)

Languages	Reading	Speaking	Writing
Hebrew			
English			
Other (specify)			

20. Type of proof for language skills: \_\_\_\_\_

21. Present occupation: \_\_\_\_\_



## MEDICAL HEALTH CERTIFICATE

1. Name: \_\_\_\_\_

2. Place of birth: \_\_\_\_\_

3. Date of birth: \_\_\_\_\_

4. Address: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

5. Person to be notified in case of emergency:

Name: \_\_\_\_\_

Full address: \_\_\_\_\_

\_\_\_\_\_

Telephone no.: \_\_\_\_\_

Cell phone no.: \_\_\_\_\_

Fax no.: \_\_\_\_\_

E-Mail: \_\_\_\_\_

**The following details are to be supplied by a registered medical practitioner:**

1. Past medical history: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
2. Present state of health: \_\_\_\_\_  
\_\_\_\_\_
3. Results of general examination:  
Blood pressure: \_\_\_\_\_ Weight: \_\_\_\_\_ Height: \_\_\_\_\_
4. Is the applicant suffering from:  
An infectious disease? \_\_\_\_\_  
A skin disease? \_\_\_\_\_  
A psychological disorder? \_\_\_\_\_  
Cardiac condition? \_\_\_\_\_  
Any other diseases? \_\_\_\_\_
5. Remarks: \_\_\_\_\_  
\_\_\_\_\_
6. Is the applicant in good health and able to physically and mentally engage  
in intensive studies in a foreign country? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of examining physician

Signature of examining physician

\_\_\_\_\_

\_\_\_\_\_

Date of examination: \_\_\_\_\_

**To be signed by the applicant:**

I, the undersigned, declare that all of the above information in this application forms is complete and accurate to the best of my knowledge. I am aware that giving incorrect answers to any of the above questions may lead to the cancellation of my application.

Date: \_\_\_\_\_

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

\_\_\_\_\_