MASTER CBRNe
Chemical, Biological, Radiological, Nuclear and explosive
Department of Industrial Engineering and School of Medicine and Surgery

Application Form Master Course in "Protection against CBRNe Events"

Level

Name _____

Surname _____

Gender

Address *(Street, Number)* _____City _____

Zip Code _____ State_____

Date and Place of Birth *(dd/mm/yyyy)* _____

Nationality _____

Telephone _____ Fax _____

E-mail _____ ID Document/Passport Number _____

Higher Level Degree *(Bachelor Degree, Master Degree)* _____

In _____

Name and Location of University _____

Date of the Degree *(dd/mm/yyyy)* _____

Mark/Level Degree _____

Please, fill it in and send it to: info@mastercbrn.it

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