

Visiting Status Registration

Sponsoring staff should complete this form at least 2 months in advance of the proposed visit.

The signature section on page 2 must be completed before submission.

**PLEASE COMPLETE IN BLOCK CAPITALS OR TYPESCRIPT ONLY – INCOMPLETE OR ILLEGIBLE FORMS WILL BE RETURNED UNPROCESSED.**

|  |  |  |  |
| --- | --- | --- | --- |
| Surname  |  | Title  |  |
| Forename(s) |  | Gender |  |
| Insurance Details |  | Phone  |  |
| Document |  | Date of Birth |  |
| Country of Birth |  | Nationality |  |

|  |  |
| --- | --- |
| Personal Email Address**MUST BE COMPLETED** |  |
| Correspondence Address |  |
|  |  |
|  |  |
| Post Code |  |
|  |  |  |  |

|  |  |
| --- | --- |
| Department |  |
| Supervisor / PI |  |

|  |  |
| --- | --- |
| Affiliate role title (Student, Scientist, Professor) |  |
| Please detail the nature of the role & whom working with |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Start Date |  |  | Expected earliest end date |  |



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**Data Protection Statement**

The University of Naples Federico II requires to collect, process and retain, certain personal data relating to you, by virtue of your role in the University. All personal data provided by you will be treated strictly in accordance with the terms of the data protection law of EU Member States and the General Data Protection Regulation (GDPR).

**Applicant Certification**

I hereby certify that the information given (on extra pages if applicable) is complete and correct.

|  |  |  |  |
| --- | --- | --- | --- |
| **Applicant Signature**  |  | Date |  |

**Department to complete**

**I authorise this registration.**

|  |  |  |  |
| --- | --- | --- | --- |
| **Director of Department Signature** |  | Date |  |
| **Director of Department****Name** |  |  |  |
| **Administrative Contact Name** |  | Phone |  |

Please return completed form to:

Carmen Di Giovanni

Department of Pharmacy

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Email: internationalfarmacia@unina.it