Attachment 1>

SUN MOON UNIVERSITY
STUDENT EXCHANGE PROGRAM APPLICATION FORM

***Even if the class goes online(Due to Covid 19), you'll still want to participate: □ YES □ NO**
*Please check □the relevant box above

PLEASE TYPE CLEARLY AND PRINT (DO NOT WRITE IN HAND)

PERSONAL INFORMATION

Attach a Photo Here

Name:
(First) (Middle) (Family)
Passport No.: _____
Nationality: _____
Date of Birth (day/month/year):_____
Gender: □ Male □Female
Marital Status: □ Married □ Single
Blood Type: □A □B □O □AB +/-
Staying period: **one semester(we only have one semester course)**
Program: □ Intercultural Studies + Korean Study Program □ Major Studies(A
**Please check □the relevant box above.*

EDUCATIONAL BACKGROUND

University: _____
Faculty: _____ Department: _____ Major:
Year / Semester: ___ /
Language Proficiency: (TOEFL: PBT/CBT/IBT), (TOPIK:), (Other:)
Academic Achievements (GPA):_____(4.5 scale)_____(100 scale)

CONTACT INFORMATION FOR STUDENT

Home Address: _____
Mailing Address:
Telephone: _____ E-mail address:

PARENTS OR GUARDIAN

Name: _____ Relationship: _____
Telephone: _____ Fax or E-mail:
Job (title/company):

Attachment 2>

XXXXXXXXXXXXXXXX UNIVERSITY
Address: XXXXX, XXXXXXXXXXXXXXXX
Tel: XXXXXXXX Fax: XXXXXXXX

LETTER OF RECOMMENDATION

To: President,

Sun Moon University

Re: Name:
Gender:
Nationality:
Date of Birth:
Department / Faculty:
School Year:

In view of the above student's exemplary conduct and superior academic achievements, and on the recommendation of the respective faculty members, we hereby recommend the above student as a candidate for the Sun Moon University.

Academic Advisor
Name: _____ Signature:
Date:

Director, International Affairs or Student Affairs
Name: _____ Signature:
XXXXXXXXXX University Date:

Attachment 3>

Study Plan

Name	
Nationality	
Major	

Personal Statement

Attachment 4>

Certificate of Health

1. Personal Information

Full Name: _____

Age: _____ Sex: _____

Date of Birth: _____

Nationality: _____

2. Physical Examination

Weight ____kg Height ____cm

Blood Pressure: Systolic ____ Diastolic ____mmHg

Vision: Right 20/ _____Left 20/ _____Color Vision _____

Corrected: Right _____/15 Left _____/15

Dental Evaluation: Good ( ) Fair ( ) Poor ( ) Needs Attention ( )

Clinical Evaluation:

Classification	Normal	Abnormal	Classification	Normal	Abnormal
Skin			Heart		
Head & Face			Abdomen		
Eyes			Rectum		
Ears			Genitalia		
Mouth & Throat			Extremities		
Nose & Sinuses			Back & Spine		
Neck			Neurological		
Chest & Lungs			Mental		
			Other		

If Abnormal:_____

3. Chest X-ray Examination

. Date taken:_____

. Findings:_____

4. Laboratory Examination

Hemoglobin: _____Gm/dl _____

Urine: S.G. _____Sugar _____Micro_____

.Hepatitis B: _____

.Stool for Parasite Oval:_____

.Serological Test for Syphilis & AIDS :_____

. Other:_____

This is to certify that the above named applicant has gone through a general medical examination and the findings indicated here are true to the best of my knowledge. In my opinion his/her health condition is;

Excellent ( ) Good ( ) Fair ( ) Poor ( )

Date	
M.D	
Signature	

Hospital or Institute