

**Pellegrinagg ghal Lourdes**  
bejn it-28 ta' Awwissu u is-2 ta' Settembru 2024  
Prezz: €648 + €52 taxxi = €700

**APPLIKAZZJONI GHALL-PERSONNEL**



**This form must be filled up correctly and completed fully so that application can be processed**

Isem u Kunjom: Dr/Mr/Mrs/Ms/Miss \_\_\_\_\_  
(bhalma jidher fuq il-passaport/ ID card)

Indirizz: \_\_\_\_\_ POSTCODE: \_\_\_\_\_

Tel No: \_\_\_\_\_ Mobile No: \_\_\_\_\_ I.D. No. \_\_\_\_\_

Data tat-Twelid: \_\_\_\_\_ Email: \_\_\_\_\_

PASSAPORT Nru: \_\_\_\_\_ Data tal-Hrug: \_\_\_\_\_ Data tal-Gheluq: \_\_\_\_\_

Impieg \_\_\_\_\_

Next of Kin \_\_\_\_\_ Mobile No: \_\_\_\_\_

Tbaghti minn xi marda jew kundizzjoni?  IVA / LE (Jekk IVA, imla' wara)

**Importanti li jkollok medical insurance(Group travel insurance hija possibli) u l-European Health Insurance Card**

Jien nixtieq naqsam il-kamra ma \_\_\_\_\_

Jien nixtieq nhallas sabiex jkolli Single Room (100 euro)

**Inti lest/a li tghin il-marid billi: {immarka fejn japplika}**

Taqsam il-kamra ma marid/a  Iva / Le Tghin biex tahsel lill-morda  Iva / Le

Tigbed Karozzella  Iva / Le Timbotta wheelchair  Iva / Le

Titma lil xi morda  Iva / Le

Data \_\_\_\_\_ Firma \_\_\_\_\_

L-ebda applikazzjoni ma tigi accettata minghajr **depożitu ta' €100 (Cheque pagabbli lil "A.V.L.")** jew bank transfer **HSBC Account No 033-203134-050 IBAN MT27MMEB4433600000033203134050**. Jekk ser taghmel bank transfer ibghat kopja tal-pagament ma l-applikazzjoni.

Din l-applikazzjoni trid tasal fl-indirizz ta' hawn taht mhux aktar tard mill-**31 ta' Mejju 2024**:

Importanti li kulhadd ikun hallas il-membership 10 euro.

Ghal dawk li ghadhom ma halsux importanti li timlew il-formola u tistghu tibghatuha flimkien ma din l-applikazzjoni.

**Louise Cini,  
142, Ginjeri Court, Appt 4  
New Mill Street  
Mellieha**



**Ċertifikat Mediku għall-PERSONNEL**

Isem u Kunjom: \_\_\_\_\_ ID No. \_\_\_\_\_

**Medical Conditions:**

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**Treatment being undertaken for above or other:**

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**Remarks (cannot walk long distances, shortness of breath, chest pain, overweight, special needs/meals, etc.)**

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Signature of Doctor \_\_\_\_\_ Date \_\_\_\_\_

Name in Block Capitals: \_\_\_\_\_ Med. Reg. No. \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Tel No: \_\_\_\_\_

**STAMP:**

