**Erasmus Application Form**

**ERASMUS STAFF MOBILITY -staff training**

 **for the academic year 20\_\_/20\_\_**

**work plan**

(to be filled out by teaching, administrative and technical staff who apply for mobility with the intent of professional training )

|  |  |
| --- | --- |
| Name of staff member |  |
| Name of home institution (Erasmus ID code) |  |
| Contact person at home institution(head of department/office/institute or dean of faculty) |  |
| Position of contact person at home institution |  |
| Office/department/unit |  |

|  |  |
| --- | --- |
| Name of host institution(Erasmus ID code) |  |
| Duration of mobility; mark no. of days\* (days spent on travel do not count) | 1 | 2 | 3 | 4 | 5 |
| Agreed time of mobility (dates) |  |
| Name of contact person at host institution |  |
| Position of contact person at host institution |  |

|  |  |
| --- | --- |
| Office/department/unit at host institution within which the candidate will do their training  |  |
| Size of the sending institution/enterprise:Small: 1-50 staff; medium: 51-500 staff; large: 501 or more staff |  |
| Sector (type of host enterprise) |  |
| Field/subject of training  |  |
| Activities to be carried out and, if possible, the programme for the period | Day 1 |  |
| Day 2 |  |
| Day 3 |  |
| Day 4 |  |
| Day 5 |  |
| Overall aims and objectives of mobility |  |
| In what way will the stay of the candidate at host institution contribute to carrying out their professional duties at their home institution  |  |
| Expected results |  |
| Other |  |

*\*In choosing grant recipients, the correlation between the duration of stay at the foreign institution and the working and teaching load will be taken into account.*

|  |  |
| --- | --- |
| **TEACHER**Date | Signature …………………………………………. |

|  |  |
| --- | --- |
| Home institutionThis is to confirm that the proposed teaching programme is approved. | Host institutionThis is to confirm that the proposed teaching programme is approved. |
| NameDateSignature…………………………………………….Head of the Department | Name DateSignature……………………………………………….Head of the Department or Contact Person |
| Stamp | Stamp: |