Field Exposure Visit

December 14 - 18, 2015

### REGISTRATION FORM

*(Kindly fill up in the space provided. Use capital letters.)*

**Previously attended training programme:** ……………………………………………………

**Contact Details**

Name (Mr./Ms/Dr.):…..…………….……………………………………………………...………..

Qualification: …........................................................................................................................

Designation and Organization:……………………………………………………………………...

Official Address: ……………………………………………………………….……..……………..

……………………………………………………………………. PIN ……………..………………

Phone No.: …………………………………….. Fax No:………………………………………

Official Email: ……………………………………Website:……………………………………….

Residential Address:…………………………………………………………………..……………

Phone No. (Res.): ………………………………......................................................................

Personal Email: ……………………………………………………..………………………………

|  |  |  |
| --- | --- | --- |
| Name | Relationship with participant | Contact number |
|  |  |  |

Emergency contact:

**Medical Details**

1. Do you have medical insurance? If yes, kindly provide the name of the company and the amount insured.

…………………………………………………………………………………………..

………………………………………………………………………………………….

1. Do you have any history of chronic illness? Kindly give details.

……………………………………………………………………………………………..

……………………………………………………………………………………………..

1. Kindly provide details of medication you take in case of emergency (e.g. inhalers, life-saving drugs etc).

…………………………………………………………………………………………….

…………………………………………………………………………………………….

**Expression of Interest**

What are your expectations from this field exposure visit? …………………………………

……………………………………………………………………………………………………..

……………………………………………………………………………………………………..

……………………………………………………………………………………………………..

|  |  |
| --- | --- |
| Kindly tick mark (✓) as per interest. | |
| Visit to northern states: |  |
| Visit to southern states: |  |

Signature …………………………..