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.

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

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

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**Expression of Interest**

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

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

Signature …………………………..