Training Programme on

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| Paste your Photograph  here |

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### REGISTRATION FORM

Name: (capital letters) (Mr./Ms/Dr/Prof.)

…………………………………………….……………………………………………..

Nationality ……………………………………………………………………………….

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

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

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

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

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

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

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

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

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

Emergency Contact: ………………………………Phone No.:………………………….

Relation with Participant….………………………………………………………………

How did you come to know about this training programme? ………………………….…

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What are your expectations from this training programme? ……………………………..

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**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?

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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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Signature …………………………..