Training Programme on

_____
_____
_____

Date: _____

Paste your Photograph here

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? ……..…

…… ……..…

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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2. Do you have any history of chronic illness?
   ……

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   ……

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