



Registration Form

Date: ___/___/___

Name of the Course: _____

Personal Details:

Name: _____

Organization: _____

Contact address: _____

Telephone: _____ Fax: _____ Email: _____

Academic and Professional details:

Academic qualifications: _____

Current position: _____

Brief description
of tasks involved
with current position

Expectation from the course: _____

Financial information:

* Cheque * Pay order enclosed Cash

** cheque/payorder in favor of Healthconsult Associates Ltd*

Signature of the participant

Signature of employer