TAMILNADU HOSPITAL

TRAINING PROGRAMME

DATA FORM

Please affix your recent photo

Name: Mr.□ Ms.□	First Name	Middle Name	Last Name
Name of College/ University:			
Address:	District:		Pin code:
Contact No:	Mobile Number:		Residence Number:
Email ID:			
Educational Background:	□ Graduate □ Post Graduate □ PhD □ Other (specify)		
UG/PG/PhD/Others Department:			Year:
Selected Course:	Name of Course: Period of Course: Selected month & Date:		
Accommodation required	□ Yes	□ No	
What would you like to learn in particular during this training program?			
Payment Details	□ Cash	□ Cheque Details:	□ Online Transfer Details:

I hereby confirm that the data submitted is true to my knowledge and I agree to the terms and conditions stated in the techno-commercial offer

Place:	Name of Participant:
Date:	Signature: