Government of Lumbini Province
Ministry of Health
Health Training Center,Butwal

TRAINER REGISTRATION FORM

Photo

PERSONAL INFORMATION

Name (in Block Letter) :- ……

नेपालीमा : ……

Sex :- ☐ **Male** ☐ **Female** ☐ **Other (Specify) :-** ……

Date Of Birth (yyyy/mm/dd) (BS):- ……

HOME ADDRESS

Province :-……**District:-** ……

Municipality :-…… **Ward No. :-**……

Phone No.:- ……

Email:- ……

QUALIFICATION

A. ……

B. ……

C. ……

D. ……

Name of Training Conducted (In Past 5 Years)/If Co-Training name of training cotrained

Working Place & Experience

Area Specialization: - ……

Current Designation: - ……..

Current Organization :- …… **Level**……

Province: - …… **District:-** ……**Municipality :-**……

Phone No.:- …… ……**Fax:-**……

Sitrol No.:- …… **Huric No.:-** …… **Citizenship No.:-**…… **Council Reg. No:-** ……

PROFESSIONAL EXPERIENCE (Clinical Training Serviced Join Date)

A. ……
B. ……
C. ……

- Enclose the Copy of Specialized Training Certificate/ Clinical T`raining.

……
Trainer's Signature

……
Head of Institution