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photo

APPLICATION FORM FOR ELECTIVE TRAINING COURSE (for Medical Doctors)

FAMILY NAME:		Nationality:
GIVEN NAME(S)		Personal email address:
Present medical qualification:		
From Hospital/Medical center :		
Address of Hospital/Medical center:		
Elective Training course:		
Course term: (From...to....)		

Date: ____/____/_____

- Please send the fully filled to the Training Center, CRH by the e-mail address mentioned upon
- The recommendation letter, photo, and brief CV, Medical diplomas should be sent together with this form by attached files