## Asia pacific Medical Students' Training - Nepal

# REGISTRATION FORM



|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Note : Use Capital letters to fill up the form . e- signature will be valid . | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Today’s date: | | | | | | | | | | | | | | | | | | | Time : | | | | | | | | |
| Applicants INFORMATION | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last name: | | | | | | | | | | First: | | | | | | | Middle: | ❑ Mr.  ❑ Mrs. | | | | ❑ Miss  ❑ Ms. | | | Marital status (circle one) | | |
|  | | | | | | | | | | | | | | | | | | Single / Mar / Div / Sep / Wid | | |
| Is this your legal name? | | | | | If not, what is your legal name? | | | | | | | | | | (English name): | | | | | | | | Birth date: DD/MM/YYYY | | | | |
| ❑ Yes | | ❑ No | | |  | | | | | | | | | |  | | | | | | | | / / | | | | |
| Age: | | Sex: | | | ❑ M | | | | | | | | | | ❑ F | | | | | | | | Others | | | | |
| Street address: | | | | | | | | | | | | | | | ID no.: | | | | | | | | phone no.: | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | |  | | | | |
| P.O. box: | | | | | City: | | | | | | | | | | State : | | | | | | | | | | | ZIP Code: | |
|  | | | | |  | | | | | | | | | |  | | | | | | | | | | |  | |
| Occupation : | | | | | University : | | | | | | | | | | | | | | | | | | | | | Grade : | |
|  | | | | |  | | | | | | | | | | | | | | | | | | | | |  | |
| Passport Number : | | | | | | Birth date: DD/MM/YYYY | | | | | | | | | | Address (if different): | | | | | | | | | | Phone no.: | |
|  | | | | | | / / | | | | | | | | | |  | | | | | | | | | |  | |
| Date of Issue : | | | | | | Expiry Date : | | | | | | | | | | Issued from : | | | | | | | | | | Birth place : | |
|  | | | | | |  | | | | | | | | | |  | | | | | | | | | |  | |
| Have you travelled to Nepal before | | | | | | | ❑ Yes | | | | ❑ No | |  | | | | | | | | | | | | | | |
| Email Address : | | | | | | |  | | | |  | |  | | | | | | | | | | | | | | |
| Skype ID | | | | | | |  | | | |  | |  | | | | | | | | | | | | | | |
| Health Status | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Blood Group / Rhesus | | | On Regular Medication  (Please specify) | | | | | | | | | | | | | | | | | Medication(please specify) | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | |  | | | | | | | |
| Allergy: | | | | ❑ Yes | | | | | ❑ No | | | Specify (if any) | | | | | | | | | | | | | | | |
| Others : | | | |  | | | | |  | | |  | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Food Specification | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Meal restrictions | | | | | | | | ( nil / Vegetarian / pork -free / chicken / Mutton ) please underline | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Others( food allergy/ intolerance) / Nil | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| Food Recommendation ( if any ) | | | | | | | |  | | | | | | | | | | | | | | | | | | | |
| IN CASE OF EMERGENCY | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Name of local friend or relative : | | | | | | | | | | | | | | Relationship : | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |  | | | | | | | | | | | | | |
| Home phone no.: | | | | | | | | | | | | | | Work phone no.: | | | | | | | | | | | | | |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Asia pacific Medical Students' Training - Nepal or insurance company to release any information required to process my claims. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  |  | | | | | | | | | | | | | | | | | | | |  | | |  | | |  |
|  | Patient/Guardian signature | | | | | | | | | | | | | | | | | | | |  | | |  | | |  |
|  |  | | | | | | | | | | | | | | | | | | | |  | | | Date | | |  |