



COURSE REGISTRATION FORM

ACAD-FRM-004

Rev#:00

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Date Revised: 21-05-2009

Owner: EIMA

COURSE APPLIED FOR: _____ DATE: _____

NAME IN ENGLISH: _____

NAME IN ARABIC: _____

NATIONALITY: _____ PASSPORT/ ID NO.: _____

PLACE OF ISSUE: _____ DATE OF ISSUE / EXPIRY: _____

DATE OF BIRTH: _____ SEX: _____ (M) _____ (F)

DESIGNATION / JOB TITLE: _____

COMPANY NAME: _____

ADDRESS: _____

PHONE: (Home) _____ (Business) _____ (Mobile) _____

E-MAIL: _____

PRINTED NAME SIGNATURE

DATE: _____

For Official Use:

TOTAL CASH RECEIVED: AED _____

For Official Use:
Received by:



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MEDICAL & EMERGENCY INFORMATION

Please check (X) those that apply: (Provide necessary details on reverse side of this sheet.)

CHRONIC AILMENTS		ALLERGIES	
ASTHMA, OR OTHER RESPIRATORY PROBLEMS		CIRCULATORY OR HEART PROBLEMS	
DIABETES OR HYPOGLYCEMIA		EPILEPSY	
HEMOPHILIA, OR OTHER BLEEDING PROBLEMS		FOODS	

CURRENT MEDICATIONS IF

ANY: _____

PHYSICIAN WHO CONDUCTED YOUR MOST RECENT PHYSICAL EXAMINATION:

PHYSICIAN'S NAME	PHONE NUMBER	DATE OF LAST EXAM

HEALTH INSURANCE CARRIER	INSURANCE ID NUMBER

I, the undersigned, do hereby authorize and consent to any x-ray examination, anesthetic, medical or surgical diagnosis or procedure rendered under the general or specific supervision of any member of the medical staff or of a dentist licensed under the provisions of the Public Health Law of the State and on the staff of any hospital holding a current operating certificate issued by the Department of Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

IN CASE OF EMERGENCY CALL:

NAME	RELATIONSHIP	PHONE NUMBER(S)

SIGNATURE OF APPLICANT: _____ DATE: _____

(If over 18 signature of participant; if under 18, signature of Father, Mother or Guardian is required)