KwaZulu-Natal Participant/Facilitator Registration Form

Personal Information			
Type of Participant (please tick): Facilitator ☐ Participant ☐			
1. Training Name			
2. Today's date			
3. Title (Please tick)	☐Dr. ☐Mr. ☐Mrs. ☐Ms. ☐Prof.		
4. Full Names *			
5. Surname*			
6. Persal Number*		**ID /Passport Number**	
7. Professional Body (e.g. SANC #)		**Professional Reg No**	
8. Gender* (Please tick)	☐**Female** ☐**Male**		
9. Disability	☐Yes ☐No		
10. Race	☐African ☐White ☐Indian ☐Coloured		
11. Birth date	Day Month Year		

Current Contact Information		
Facility		
12. Province*		
13. District*		
14. Sub District*		
15. Facility Name*		
16. Facility type (Please tick)	☐ Academic (Medical/Nursing/Other College) ☐ Community Health Centre ☐ Hospital ☐ Primary Health Centre	☐ Hospital – inpatient ☐ Hospital – outpatient ☐ NGO-supported (managed, financed) ☐ Other (Please specify)_____ ☐ Training Center
Address and Phone		
17. Postal Address		
18. Work phone		
19. Mobile phone		
20. Email		
21. Fax		

Qualifications			
22. Occupational category* (Please tick)	☐ Professional Nurse ☐ Enrolled Nurse ☐ Enrolled Nursing Assistant ☐ Medical Doctors ☐ General Worker ☐ Dieticians ☐ Lay Counsellor	☐ Dentist ☐ Assistant Dentist ☐ Paramedical ☐ Pharmacist ☐ Pharmacy assistant ☐ Medical Student ☐ Community Health Worker	☐ Social Auxiliary Worker ☐ Administrator ☐ Social Worker ☐ Clinical Associate ☐ Data Capturer ☐ Other (Please specify) _____