The Indus Hospital

Infection Control Department

Registration Form

Hospital Infection Prevention and Control

Registration #_____ Date:_____

Course:_____

Name:_____ DOB:_____

Gender: _____ CNIC #_____

D/O, S/O, WS/O _____

Cell #_____ Land line #_____

Address_____

_____

Academic Record:

Qualification	Board/School	Year to	MarksGrade

Clinical Experience:

Hospital Name	Area	From-To	

Note: NOC will be required for admission.

Name/ Signature:

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