DEPARTMENT OF MEDICAL EDUCATION
Swat Medical College Swat
PARTICIPANT REGISTRATION FORM

ACTIVITY INFORMATION:

Activity Title: _____

Activity Date(s): _____ Time(s): _____

PARTICIPANT'S INFORMATION:

Name: _____ Department: _____
Father name: _____ Institute: _____
Designation: _____ CNIC: _____-_____-_____
WhatsApp: _____ Email: _____
Mailing Address: _____

REGISTRATION:

Registration with (please tick box): DME ☐ Organizer: ☐
Registration fee (in figure): Rs. _____ (In words)_____
Cash: ☐ Online (Attach receipt): ☐

EXPECTATIONS FROM THE ACTIVITY: (Please briefly describe your expectations and what you hope to gain from attending the activity).

_____

_____

FINANCIAL RELATIONSHIP DISCLOSURE:

This activity is not supported by any commercial entities, and the organizers, planners, and speakers have no relevant financial relationships.

OR

If there is any commercial support or relevant financial relationships, they will be explicitly stated in the activity's advertising and signage.

DECLARATION:

I confirm that the information provided in this form is true and accurate.
I agree to abide by the rules and regulations set forth by the organizing entity.
I understand that my registration is subject to confirmation and availability.

Signature: _____

Date: _____