

Ministry of Health, Sri Lanka

National Institute of Mental Health, Sri Lanka

Workshop for Medical Administrators on the Mental Health Policy and Services of Sri Lanka

APPLICATION FORM

FULL NAME: (as it should be in the certificate)

DESIGNATION:

CURRENT WORKING/TRAINING STATION:

ADDRESS:

RESIDENCE:

WORKING/TRAINING STATION:

CONTACT NUMBER:

MOBILE:

OFFICE:

E-MAIL ADDRESS

PERSONAL:

OFFICE:

Signature:

Date:

Recommendation of the Supervising Officer/ Head of the Institute:

I recommend the participation of the above officer in the said workshop

Signature

Seal

Date