



FORM FOR PARTICIPANTS IN THE WFHSS TRAINING PROGRAMME

The WFHSS Member Association:

.....

Represented by:

First Name:

Last Name:

Email:

Phone Number:

Appoints:

Name:

Last Name:

Address:

Country:

Email:

Phone Number:

Cell Phone:

Fax Number:

To take part in the training programme of the WFHSS

Electronic signature:

DD: