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Kriger Research Group International
REGISTRATION FORM

CERTIFIED CLINICAL RESEARCH PROFESSIONAL PROGRAM

Please fill in complete requested information. Personal information provided on this form will be used for Diploma/Certificate

Applicant's Name: _____

Father's/ Husband's Name: _____

C. N.I.C. No. _____ Gender: Male Female

Postal Address: _____

_____ Tel. No.: _____

Cell No.: _____ E-Mail Address: _____

Working as: Faculty Professional Student

Job Position: _____

Organization/University: _____

What are your goals as a result of taking this course (Learning / Enhancement of Professional Knowledge / Specific Project / Career Advancement / Promotion) etc (describe briefly).

Does this course tie to any of your current or upcoming projects? If so, Please describe

From where did you get the information about this program?

Declaration

I certify that all the answers I have given are complete and accurate to the best of my knowledge and belief. If admitted, I agree to observe all the rules and regulations of Kriger Research Group International I certify to bear all expenses of the program of study.

Date: _____

Signature of Applicant: _____

Note: Please attach Fee payment Slip, Resume/CV, CNIC (Photocopy), Graduation Transcript/Marksheet

For Official Use Only

Student Name: _____ Course Fee: _____

Registration No.: _____ Sign & Date: _____