**Application for intensive 4-day workshop in managing HIV-AIDS**

*with interactive case discussions and clinical cases*

**Venue:** Center of Excellence, 6th floor, JJ Hospital Main bldg, Mumbai **When:** 29th May 5th, 12th& 19th of June 2011 (all Sundays) from 9 am - 5 pm

**Please fill out the following form and return to register@cmhealthfoundation.org or mail to Regd office**

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| --- | --- | --- | --- | --- | --- |
| **Full Name\*** | | | **Name as wanted on certificate\*** | | |
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| **Postal Address\*** | | | | | |
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|  | | | | | |
| **City** |  | | | **Pin** |  |
| **Mobile Phone\*** | | **Clinic phone** | | | |
|  | |  | | | |
| **e-mail ID\*** | | **Confirm e-mail ID\*** | | | |
|  | |  | | | |
| **Edu. qualification(s) *with year of passing & name of college / university*** | | | | | |
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| **Registration no with name of Medical Council** | | | | | |
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| **Any hospital attachment/ affiliation** | | | | | |
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| **Are you already practicing HIV medicine OR intend to start practice?** | | | | | |
|  | | | | | |
| **Do you agree to practice ONLY using National AIDS policy guidelines?** | | | | | |
| **Yes/  No (give reasons)** | | | | | |
| **Do you agree to use uniform guidelines for maintaining records?** | | | | | |
| **Yes/  No (give reasons)** | | | | | |
| **Do you agree to share data of PLWHA under your care (maintaining the confidentiality) so as to create a registry of cases managed at community level?** | | | | | |
| **Yes/  No (give reasons)** | | | | | |
| **There is a proposal of setting up a chain of “HEALPositive” clinics where ethical, standardized treatment of HIV is given. Do you wish to be part of the chain? (Details, advantages & commitments available on request)** | | | | | |
| **Yes/ No** | | | | | |