Registration Form

Name of Program
(Please tick)

☐ Low Vision Care (3 months) ☐ Low Vision Awareness (3 days)

Period ____________________ To ____________________

Name ____

Sex ____________________ Age ____________________

Qualifications ____

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(Please enclose copies of certificates)

Institution/Individual Practice ____

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Mailing Address ____

____

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Email ____

Telephone ____

Fax ____

Signature of participant Date

Vision Rehabilitation Centres

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