CRITICAL CARE NURSES ASSOCIATION OF NEPAL (CCNAN)
MEMBERSHIP FORM

Date:

Personal Details:

First Name Middle Name Last Name

Address:

Institution:

Working Area:

Telephone no Residence: _____ Mobile No: _____

Email address:

Years of ICU / HCU experience:

Critical Care Training (at least of 3months):

If yes, When and where:

Type of membership:

- ☐ Life-time membership
- ☐ General Membership
- ☐ International Membership

Documents verified by:

Training site / Work experience verified by:

Final endorsement by:

Signature of CCNAN President:

INSTRUCTION:

☐ Please download this registration form, complete it and send it along with payment to the contact persons. Registration will be confirmed only after CCNAN meeting in every 3months.

Contact for further details:

E-mail: ccnannepal2016@gmail.com