Application Form for I.A.C.P. Fellowship/Training Program

Name of Candidate: _____

Age: _____ Sex:_____

Detail Postal Address: _____

_____

_____

State: _____ Pin: _____

Phone No.: _____ Email: _____

Qualification of the Candidate:

Specialty/field of interest:

Name any three Centres in which training will be given (three preferences):

Are you committed to work in field of Cerebral Palsy for 3-5 years?

Area you self sustained for accommodation and travel for fellowship program:

Area you I.A.C.P. member (I.A.C.P. membership Necessary for any fellowship):

I am binding to all rules and regulations laid by I.A.C.P. executive council in breech of which my fellowship will be terminated at any time

Signature of the Candidate