ADVANCED PROFESSIONAL CERTIFICATE COURSES

REGISTRATION FORM FOR ADMISSION

Tick (√) against appropriate course:

- ☐ **Certified Healthcare Quality Professional**
- ☐ **Certified Healthcare Project Management Professional**
- ☐ **Certified Infection Management Professional**
- ☐ **Certified Pharmaceutical GMP Professional**

Attach Passport Size Photograph Here

A. PERSONAL DATA:

1. FULL NAME : DR./MR./MS.	FATHER NAME:
2. COMPANY NAME :	
3. ADDRESS (Office): (Residence):	
4. DATE OF BIRTH (*Day/Month/ Year*):	5. C.N.I.C. NO.:
6. HOME PHONE:	7. WORK PHONE:
8. EMERGENCY CONTACT NO.:	9. E-MAIL:

B. EDUCATION: (Attach your credentials with the application)

10. DEGREE	11. COLLEGE OR UNIVERISTY *(Name, City/Country)*	12. DATES ATTENDED		13. NO. OF ACADEMIC YEARS	14. GRADE / DIVISION
		FROM *(Year)*	TO *(Year)*		

C. SUMMARY OF PROFESSIONAL EXPERIENCE:

15. POSITION	16. EMPLOYER	17. START DATE (*Month/Year*)	18. FINISH DATE (*Month/Year*)	19. YEARS IN POSITION
			TOTAL YEARS	

D. TECHNICAL TRAININGS / COURSES:

20. DESCRIPTION OF TRAININGS/COURSES	21. INSTITUTE	22. DURATION	23. DATES ATTENDED	
			FROM *(Month/Year)*	TO *(Month/Year)*

E. PROFESSIONAL MEMBERSHIPS:

24. TYPE OF MEMBERSHIP	25. PROFESSIONAL BODY	26. MEMBER SINCE

F. EMPLOYER'S APPROVAL: (In case the candidate is an employee)

1. **I certify that the information provided by the candidate is accurate and to the best of my knowledge.**
2. **I have no objection whatsoever on the candidate's admission and participation in the course.**
3. **The course fee will be paid by** ☐ **The Employer** ☐ **The Candidate**

EMPLOYER'S STAMP & SIGNATURE ____________ NAME ____________ DATE ____________

G. CANDIDATE'S VALIDATION:

I certify that the statements above including my attachments are accurate to the best of my knowledge. I hereby authorize the institute to verify any information submitted. I understand that any falsification of any information in this application or attachment may cause for rejection or withdrawal of certification.

I further agree to hold the DUHS & PIQC harmless from any additional liability in the event this application is rejected on the basis of information furnished to DUHS & PIQC by me or third person which would make me ineligible.

I further agree to adhere to the DUHS & PIQC's Code of Professional Conduct and, if I am certified, to meet the requirements of continuous certification.

APPLICANT SIGNATURE ____________ DATE ____________

DOCUMENTS TO BE ATTACHED:

(*Please ensure that the following documents have been attached and tick appropriately*)

1. Registration Fees – PKR.3000/= (Non – Refundable) With Proof of Payment ☐
2. Passport Size Photograph (Attach Above) ☐
3. Professional Degree (s) ☐
4. Updated CV / Resume ☐

(FOR PIQC OFFICIAL USE ONLY)

CHECK POINTS			
PERSONAL INFORMATION	COMPANY INFORMATION	REFERENCE DOCUMENTS	FEES PAID
CHECKED BY: (SIGNATURE)		DATE:	
REVIEW AND APPROVAL		THE APPLICATION HAS BEEN REJECTED	
REVIEW / APPROVER: (SIGNATURE)		DATE:	

PIQC Institute of Quality
Address (Karachi Office): C-5, Block 17 Gulshan-e-Iqbal, Karachi
Tel: +923332163620, +923150027826, +92234979449
Email: ikram@piqc.edu.pk, infokhi@piqc.edu.pk, piqc@cyber.net.pk
Website: www.piqc.edu.pk

Dow University of Health Sciences (DUHS)
Address: Baba-e-Urdu Road, Karachi, Pakistan Postal Code:74200
Tel:+ 92-21-99215754-57 & 021-38771000
Website: www.duhs.edu.pk