**CPD Provider Application Form**

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| **CPD Provider Application Information**  |

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| **Provider name (Arabic):**  |

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| **Provider name (English):** |

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| **Country of headquarters:**  | **Web site:**  | **Phone:**  | **Email:** |

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| --- | --- | --- | --- |
| **Provider Address:**  | **City:**  | **PO Box:**  | **Post Code:**  |

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| **Short description of the provider organization** |
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| **Official registration Number:**  | **Year:**  | **Place of registration:**  |
|  **\* Attach a copy of the registration document** |

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| **Associations, scientific institutions, and private companies related****Official registration title:** **Board Members (Management):****Advisory scientific board members:** |

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| **Contact officer** |

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| --- | --- |
| **Full Name:**  | **Position in the Organization:** |

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| --- | --- | --- |
| **Job:**  | **Phone:**  | **Email**: |

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| --- | --- |
| **Address:**  | **National ID:** |
| \* **Attach a copy of your national ID** |

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| **For Office Use** |
| **CPD Provider Name: recipient: Date of Receipt:****Application number:** |

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|  **Declaration**  |

**Service provider declaration “service provider institution “**

“I acknowledge that I am the direct person responsible for the training site of ‘Continuing Professional Development.’

Named:

Presented by:

Accreditation submission number:

that all the data provided is correct and that I have reviewed the general rules and standards regulating the activities of continuing professional development in the field of medicine, issued by the Egyptian Health Council, as well as the governing texts referred to. I commit to abide by them and any modifications or additions to them by the council.”

**Signature:**

**Date:**

 **: Seal**