MEDICAL CAMP REGISTRATION FORM

Physicians & Volunteers Who Would Like To Attend The Camp Please Provide The Following Information.

Date: _____

Name _____ **Age/Sex** _____

Street Address _____

City _____ State _____ Zip _____

Home Phone Number _____

Cell Number _____ Office Number _____

E-mail Address _____

Contact Information in India – Name _____

Address _____

_____ Phone Number _____

Date of Arrival to Camp _____ **Date of Departure** _____

CHOOSE ONE: PHYSICIAN _____ RESIDENT YEAR _____

VOLUNTEER _____ MEDICAL STUDENT YEAR _____

If Physician / Resident / Medical Students / Nurses Specify Following:

Medical Degree _____

Please Email Scan copy of Medical Certificate along with this form to : bidadahospital@hotmail.com

Country / State & Year Degree Issued _____

Medical Specialty _____

Professional Affiliation _____

If Volunteer Specify Following

Education _____

Area of Interest to Volunteer _____

E-mail Address _____

Camp Site : Bidada Hospital, Village: Bidada, Taluka: Mandvi, Kutch, Gujarat, India

Contact : Vijay Chheda, Chairman Cell: +91 98191 42447

E-mail : vijaychheda@hotmail.com