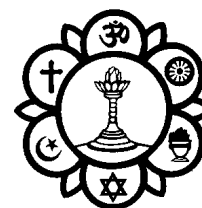




SATHYA SAI ORGANISATION

(Australia & Papua New Guinea)

Sai Medical Unit Australia



Sai Medical Camp Fiji

12th - 18th July 2008

Please kindly complete and return this form by **31st March 2008**
for our records.

PERSONAL DETAILS:

First Name:

Surname:

Gender:

Date of Birth:

Address:

Home phone no:

Work phone no:

Mobile no:

E-mail address:

PROFESSIONAL DETAILS:

Profession:

Qualification:

Registration Body:

Indemnity Insurer:

Will the Insurer provide cover for the specified dates of the camp? Yes No

Professional experience (brief):

.....
.....
.....

ADDITIONAL SKILLS/EXPERIENCES:

.....
.....
.....
.....
.....
.....
.....
.....
.....

PASSPORT DETAILS:

Full name as appears on passport:

Nationality:

Place of Birth:

Passport Number:

Date of Issue:

Date of Expiry:

Authority:

TRAVEL DETAILS:

Accompanying person/s (Please list name/s and complete Accompanying Person/s form):

Person 1:

Person 2:

Person 3:

Frequent Flyer Points details:

Travel Insurance required: Yes No

IMMUNISATION DETAILS:

Hepatitis A:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hepatitis B:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Measles, Mumps, Rubella:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Diphtheria, Tetanus, Pertussis:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Polio:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Typhoid:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Tuberculosis (BCG)/Mantoux test:	Yes <input type="checkbox"/> No <input type="checkbox"/>
Yellow fever:	Yes <input type="checkbox"/> No <input type="checkbox"/>

SPECIAL NEEDS (PLEASE SPECIFY DETAILS):

Diet:

Medical/Health-related:

Other:

NEXT OF KIN:

Name:

Relation:

Address:

Phone no:

ADDITIONAL COMMENTS/SUGGESTIONS

.....
.....
.....
.....
.....

PLEASE ATTACH THE FOLLOWING:

1. Certified copy of passport
2. A copy of Confirmation of Overseas Cover from your indemnity insurance agency
3. Certified copy of Medical Board Registration

*Please forward the completed form along with the additional attachments to the following address by the **31st of March 2008:***

***Dr Sharanyaa Sivagnanapiragasam
5/96A Baker St,
Carlingford, NSW 2118***