**Certification of Enrollment**

 Participant’s Name

 Participant’s Affiliation:

 Date of birth (Year/Month/Day):

This is to certify that the abovementioned person belongs to our institute and engages as

\*Please mark an appropriate participant’s position with a circle.

Nurse / Clinical Engineer / Medical Technologist / Nutritionist / Pharmacist / Allied Health Care Staff (to be specific: ) / Postgraduate Student / Undergraduate Student / Fellow / Junior Resident

Signed date:

Certifier’s position:

Certifier’s Name:

Certifier’s Signature: