OFFICE USE ONLY

**TRAINING REGISTRATION FORM**

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| **Title of the Training Course:** 10th BAB Assessors Refresher Course  **Date of the Course:** 20 March 2019  **Venue:** NPO Seminar Hall  **Course No:** 19032506 | | | | | | | | | | | | | | | | | | | Please attach a copy of recent Passport size color photograph here | | | | |
| Note:   1. Please answer each question clearly and completely. Use additional sheets, if necessary. 2. Only the Registrations recommended by the Supervisor/Head of the organization will be considered for final selection. | | | | | | | | | | | | | | | | | | | | | | | |
| **APPLICANT’S PERSONAL INFORMATION:** | | | | | | | | | | | | | | | | | | | | | | | |
| **First Name Middle Name Last Name** | | | | | | | | | | | | | | | **Sex** | | | | **Marrital Status** | | | | |
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| **Date of Birth** | | | | **Place of Birth** | | | | | | | | | | | **Nationality** | | | | | | | | |
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| **Present Address:** | | | | | | | | | | **Permanent Address:** | | | | | | | | | | | | | |
| **House no:** | | | **Road No:** | | | | | | | **Vill:** | | | | | | | | | | | | | |
| **Block/Sector:** | | | **Area:** | | | | | | | **Post:** | | | | | | | | | | | | | |
| **Thana:** | | |  | | | | | | | **Upazilla:** | | | | | | | | | | | | | |
| **District:** | | |  | | | | | | | **District:** | | | | | | | | | | | | | |
| **Tel. Number:** | | | | | | | | | | **Tel. Number:** | | | | | | | | | | | | | |
| **Mobile Number:** | | | | | | | | | | **Mobile Number:** | | | | | | | | | | | | | |
| **Email :** | | | | | | | | | | **Email :** | | | | | | | | | | | | | |
| **APPLICANT’S ORGANIZATION DETAILS:** | | | | | | | | | | | | | | | | | | | | | | | |
| **Name of Organization:** | | | | | | | | | | | | | | | | | | | | | | | |
| **Position/Designation :** | | | | | | | | | | | | | | | | | | | | | | | |
| **Org. Address:** | | | | | | | | | | | | | | | | | | | | | | | |
| **Org. Tel No:** | | | | | | | | | **Org. E-mail :** | | | | | | | | | | | | | | |
| **Brief Description of Org. Work:** | | | | | | | | | | | | | | | | | | | | | | | |
| **Previous Experiences and Expertise:*(****in chronological order starting with the most recent experience* | | | | | | | | | | | | | | | | | | | | | | | |
| **YY:MM (from) --YY:MM( To)** | | | | | **Field(Brief of Works)** | | | | | | | | **Designation and Organisation** | | | | | | | | | | |
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| **EDUCATIONAL QUALIFICATION(Latest First):** *Including Professional Degree (if any); add more row (if necessary) and lower level degree may be excluded if space doesn’t permit.* | | | | | | | | | | | | | | | | | | | | | | | |
| **Level/Degree** | | **Institution/ University** | | | | | | | | | **Major Area/Concentration** | | | | | | | | | **Passing Year** | | | **Class/Grade** |
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| **PROFESSIONAL ACHIEVEMENTS :** (Please describe in brief) | | | | | | | | | | | | | | | | | | | | | | | |
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| **RELEVANT TRAINING AND WORKSHOP PARTICIPATED** | | | | | | | | | | | | | | | | | | | | | | | |
| **Title** | | | | | | **Conducted by** | | | | | **Organized by** | | | | | | **Venue** | | | | | **Duration**  (from – to) | |
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| **AUDIT/ ASSESSMENT EXPERIENCE:** Where applicable please put the Number: | | | | | | | | | | | | | | | | | | | | | | | |
| **Testing Lab** | **Calibration Lab** | **Medical Lab** | | | | | **Inspection**  **Body** | **Certification**  **Body** | | | | **QMS** | | **EMS** | | **FSMS** | | **HACCP** | | | **Others** | | |
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| **Membership in Technical Societies/Bodies related to Quality (if yes, please specify):** | | | | | | | | | | | | | | | | | | | | | | | |
| **Publications (if any, please mention title, journal name and volume no.):** | | | | | | | | | | | | | | | | | | | | | | | |
| **PRIMARY OBJECTIVES TO BE ACHIEVED BY THE PROPOSED TRAINING** | | | | | | | | | | | | | | | | | | | | | | | |
| Outline the detailed programme of training/detailed subjects of interest within the desired field of study: | | | | | | | | | | | | | | | | | | | | | | | |
| **IF YOU LIKE TO ADD MORE** | | | | | | | | | | | | | | | | | | | | | | | |
| Outline the roles foreseen by the supervisor upon the applicant’s return, and how the training will be of value to meeting the needs of the organization’s objectives: | | | | | | | | | | | | | | | | | | | | | | | |
| **RECOMMENDATION FROM SUPERVISOR/HEAD OF THE DIVISION OF THE ORGANIZATION** | | | | | | | | | | | | | | | | | | | | | | | |
| **Applicant Sig:**  **Date**: | | | | | | | | | **Supervisor/Head Sig:**  **Date:**  **Mobile/Phone:**  **E-mail:** | | | | | | | | | | | | | | |