Centre for Teaching and Research in Disaster Medicine, University of Linköping

Application form

Name						
Title (professor/doctor/nurse/paramedic/ administrator)						
Speciality						
Experience as teacher (yes/no, type of experience)						
I want to register as a participant in the following course/courses	**Course**				**Date**	
Postal address						
Telephone office						
Fax						
E-Mail						
I prefer to be informed by		**Mail**		**Fax**		**E-Mail**
Date						
Signature						

Return to fax +46 13 22 29 10 or mail KMC@lio.se