**REGISTRATION FORM**

**PAPU Digital Financial Services Workshop – Arusha, Tanzania, 11-13 December 2024**

May you kindly nominate your Designated Operators’s representative to be sponsored by PAPU for participation in Workshop **by 15th November 2024 at the latest** and return the duly completed form to:

|  |  |  |
| --- | --- | --- |
| Mr. Yonna Singogo  Accounts Officer  Tel : +255 787 079 832  E-mail: [afo@papu.co.tz](mailto:afo@papu.co.tz) | Ms. Itesi Taguaba  Bilingual Secretary  Tel: +255 755 209 679  E-mail: [sc@papu.co.tz](mailto:sc@papu.co.tz) | Mr. Abdoulaye NIANG  Digital Transformation and Financial Inclusion Officer  Tel: +255 696 217 694  E-mail: [fid@papu.co.tz](mailto:fid@papu.co.tz) |

**Participant information**

|  |  |  |  |
| --- | --- | --- | --- |
| Country | | | |
| Name of Designated Operator | | | |
| Full name of the sponsored participant | | | Mr  Ms |
| Position/title | | | |
| Address | | | |
| Tel. | | Fax | |
| E-mail | | | |
| Date | | Signature | |
| **Sponsorship/Fellowship Approval** | | | |
| Authorizing Official (**CEO/PMG/Representative**) | Place and date | Signature of the designated operator’s authorized representative | |
| Position held by the signatory | | |
| Official Stamp | | |

**NB: Sponsored participants must send a scanned copy of their passports and medical report form duly signed by a medical practitioner to facilitate the issuance of tickets.**

**MEDICAL REPORT FORM**

|  |  |  |  |
| --- | --- | --- | --- |
| Applicant | Family name | | Given name(s) |
| Date of birth | Gender  Male  Female | Right-handed  Left-handed |
| Address | | |
| State of health | Satisfactory  Not satisfactory | | |
| Remarks | | |
| Working capacity | Satisfactory  Not satisfactory | | |
| Remarks | | |
| Physical and mental capability of applicant to carry out intensive study away from home | Satisfactory  Not satisfactory | | |
| Remarks | | |
| Infectious diseases  (for instance, tuberculosis and/or trachoma) from which the applicant may suffer and which could represent a risk for him/her and his/her contacts during studies | Comments | | |
| Examining physician | Name (please print) | | |
| Full address | | |
| Place and date | | |
| Signature with stamp | | |