FORM FOR COLLABORATIVE CENTRES OF WFHSS

The WFHSS Member Association: …………………………………………………………….

Represented by:

First Name: ………………………………………………………………

Last Name: ………………………………………………………….

Email: ………………………………………………………………

Phone Number: ……………………………………………………..

wishes to take part in the WFHSS training program as a collaborative centre.

Signature:

Date:

Collaborative Centre details*

Hospital:

Address:

Responsible person:

Approval of Hospital Director

Name:

Signature:

Date:

***Please add a detailed report about the CSSD including machines, packaging methods, daily numbers of sets and operations, number of staff, education level of responsible person and etc.**