WORLD FEDERATION FOR
WFHSS
HOSPITAL STERILISATION SCIENCES

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.

Date: ……..

Signature:

Collaborative Centre details*

Hospital:……

Address:……

Responsible person:……

Approval of Hospital Director

Name:……..

Date:……..

Signature:

***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.**