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| |  | | --- | | **Course Announcement**  **Method Validation & Quality Control**  **Regional Training of Trainers Workshop (*non-Teachback*)** | | **\\cdc.gov\private\M111\dbx4\Lab Support Team\Lab Management Training\SLMTA\Clearance\SLMTA 2.0 Logo\NEW_SLMTA_5.27.jpg** |

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| --- | --- | --- |
| Surname (Family Name): | | |
| Given Names: | | |
| Dr./Mr./Mrs./Ms.: | Gender: | |
| Address: | | |
| Country: | | |
| Work Telephone: | | Mobile: |
| Email: | | Alternate Email: |
| Employer: | | Job Title: |

**Answer the questions below. Keep your reply within 5 lines or 5 bullet points.**

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| Please briefly describe your Quality Control and Method Validation experience and training. |
|  |
| Please briefly describe your plans to step this training down in your country. |
|  |
| **I will be sponsored by (please check one):**  \_\_\_ CDC  \_\_\_ Employer  \_\_\_ Other (please specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Financial Proof Letter or Email Attached:**  \_\_\_ Yes  \_\_\_ No |