HEALTH DEPARTMENT
Government of
Khyber Pakhtunkhwa
حکومت خیبر پختونخوا

TIMS
Training Information
Management System

POPULATION WELFARE
DEPARTMENT
Governmnet of
Khber Pakhtunkhwa

Trainer Registration Form

PLEASE WRITE CLEARLY AND LEGIBLY IN BLOCK LETTERS

Training Category: *(Please √ check the appropriate option) (Single Selection Only)*

☐	Provincial Level Institutional Training	☐	Training of Master Trainers	☐	Rollout Training

Department (DoH/PWD): ____

District: ______________________________ Tehsil: ______________________________

City: ______________________________ Training Venue: ______________________________

Training Start date: ☐☐-☐☐-☐☐☐☐ (Day Month Year) Training End date: ☐☐-☐☐-☐☐☐☐ (Day Month Year)

Training Duration: ____________________ No. of Participants Attended: ____________________

Training organized by:

☐ Department of Health (DoH)	☐ Population Welfare Department (PWD)	***Supported by** *(Please √ check the appropriate option)*			
		☐	WFP	☐	JSI
		☐	UNICEF	☐	Jhpiego
		☐	UNFPA	☐	RSPN
		☐	WHO	☐	Contech
		☐	Others ______________________________		

Type of Training: *(Please √ check the appropriate option) (Single Selection Only)*

1	Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC)	2	Managing Complications in Pregnancy and Childbirth (MCPC)	3	LHW Training Module
4	Helping Babies Survive (HBS)	5	Community IMNCI	6	Integrated Management of Neonatal and Childhood Illness (IMNCI)
7	Chlorhexidine for cord care	8	Family Planning Compliance	9	District Action Plan
10	Infant & Young Child Feeding (IYCF)	11	Lactation Management and Growth Monitoring (GM)	12	Post-Partum Family Planning (PPFP)
13	Infectious Diseases	14	Case management of infectious diseases	15	Infection Prevention and Control at health facilities
16	Biosafety and safe laboratory practices	17	Disease surveillance and response	18	Monitoring & Supervision Training
19	Management Information System Training	20	Hospital Waste Disposal Training	21	Others__________________

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Type of trainee/training participant: *(Please √ check the appropriate option) (Multi Selection)*

☐	Master Trainers	☐	Health Manager	☐	Doctor
☐	Lady Health Worker (LHWs)	☐	Community Midwifery (CMWs)	☐	Lady Health Visitor (LHV)
☐	Field Technician Officer (FTO)	☐	Female Welfare Worker (FWW)	☐	Female Welfare Counsellor (FWC)
☐	Women Medical Officer (WMO)	☐	Medical Officer (MO)	☐	Others

Scanned Attendance sheet Attachment: ____________________ Picture of Training Attachment _______________

Training Report Attachment: ______________________________

TRAINER'S PERSONAL INFORMATION

Trainer Type:

☐ Course Director	☐ Co- Course Director	☐ Facilitator	☐ Co-facilitators	☐ Clinical Instructor

First Name: ________________________________

Last Name:___________________________

CNIC Number: __ __ __ __ __ - __ __ __ __ __ __ __-__

Gender: ☐ Male ☐ Female ☐ Transgender

Qualification: ______________________________

Job Title: ___________________________________

Experience as Trainer *(in Years)*: _______________

Experience / Specialization (in Years)_____________

Experience in this particular field:_______________

Department: ________________________________

District: _____________________________________

Tehsil: ____________________________________

Place of work: _______________________________

Type of Facility/Facility Name:

____

Professional Registration Number: __ __ __ __ __

Mobile Phone Number: _______________________

Email Address : _____________________________

PTCL Landline: ______________________________

You are professionally serving at which level? *(Please √ check the appropriate option) (Single Selection Only)*

☐ Community Level	☐ Health Facility Level

Your serving Cadre. *(Please √ check the appropriate option) (Single Selection Only)*

☐ Clinical	☐ Management

Trained as Trainer in other fields:

1. ____________________________, 2. ____________________________, 3. ____________________________

Comments: Please include any additional comments about this training.

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Participant Registration Form

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Training Category: *(Please √ check the appropriate option) (Single Selection Only)*

☐	Provincial Level Institutional Training	☐	Training of Master Trainers	☐	Rollout Training

Department (DoH/PWD): ____

District: ______________________________ Tehsil: ______________________________

City: ________________________________Training Venue: _________________________

Training Start date: ☐☐-☐☐-☐☐☐☐ Training End date: ☐☐-☐☐-☐☐☐☐

Day Month Year Day Month Year

Training Duration: ____________________

Training organized by:

☐ Department of Health (DoH)	☐ Population Welfare Department (PWD)	***Supported by** *(Please √ check the appropriate option)*			
		☐	WFP	☐	JSI
		☐	UNICEF	☐	Jhpiego
		☐	UNFPA	☐	RSPN
		☐	WHO	☐	Contech
		☐	Others :		

Type of Training: *(Please √ check the appropriate option) (Single Selection Only)*

1	Pregnancy, Childbirth, Postpartum and Newborn Care (PCPNC)	2	Managing Complications in Pregnancy and Childbirth (MCPC)	3	LHW Training Module
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Type of trainee/training participant: *(Please √ check the appropriate option) (Single Selection Only)*

☐	Master Trainers	☐	Health Manager	☐	Doctor
☐	Lady Health Worker (LHWs)	☐	Community Midwifery(CMWs)	☐	Lady Health Visitor (LHV)
☐	Field Technician Officer (FTO)	☐	Female Welfare Worker (FWW)	☐	Female Welfare Counsellor (FWC)
☐	Women Medical Officer (WMO)	☐	Medical Officer (MO)	☐	Others

PARTICIPANTS' PERSONAL INFORMATION

First Name: ________________________________

Last Name:_______________________________

CNIC Number: __ __ __ __ __ - __ __ __ __ __ __ __ - __

Gender: ◻ Male ◻ Female ◻ Transgender

Qualification: __________________________________

Job Title:______________________________________

Department: __________________________________

Tehsil: ____

District: _______________________________________

Professional Registration Number: __ __ __ __ __ __ __ __

Place of work/Facility Name:_____________________

Mobile Phone Number: __________________________

Type of Facility: _________________________

PTCL Landline Number:__________________________

Email Address : _________________________________

You are professionally serving at which level? *(Please √ check the appropriate option) (Single Selection Only)*

☐ Community Level	☐ Health Facility Level

Your serving Cadre?*(Please √ check the appropriate option) (Single Selection Only)*

☐ Clinical	☐ Management

Trainings attended in last three years 2016 /2017 /2018 *(Please mention trainings' name)*:

1. ____________________________, 2. _____________________________, 3. _____________________________

TRAINING TEST SCORES (This section to be completed by trainer)

a. Pre-Test Knowledge Score:___________ Post-Knowledge Test Score:________________ Max Score:______

b. Pre-Test Skill Score: ________________ Post-Test Skill Score:______________________ Max Score:______

Trainer's Name: ____ Signature: ___________________________________

Comments: ____

Follow-up Score (This section to be completed by Follow up official)

Name of follow up Supervisor: ____________________ Date of follow up visit: ______________________________

c. *Post training follow up score after 2-3 month: ________________ Signature: ___________________________

Comments: ____