

REGISTRATION FORM



TRAINING ON : GROWTH STRATEGY FOR MICROFINANCE INSTITUTIONS

Kigali, Rwanda | November 12-14, 2025

Name of Candidate:

Year of Attendance:

Sex: Male ☐ Female ☐

Date of Birth:

Mailing Address (Business):

Country: City: Street:

P.O.Box:

Tel :(office),(cell/mobile)

Fax:

Email:(office)(personal)

Name of Institution:

Present Position:

Number of Years in this Position:

Main Responsibilities:

Number of Years in Microfinance:

Academic Qualification:

Year of Graduation:

Area of Study:

Language Proficiency: (Fluent in English ☐ Yes ☐ No)

Computer Literate ☐ Yes ☐ No

Signature: Date:

Authorized by (Name): Position:

Tel:Email:

Signature: Date: