



MINISTRY OF HEALTH



REGENERATIVE HEALTH AND NUTRITION PROGRAMME (RHNP)

SERVICE REQUEST FORM

Date/...../.....

NAME OF ORGANIZATION:

TYPE OF INSTITUTION:

LOCATION:

ADDRESS:

CONTACT PERSON:

TELEPHONE (OFFICE): (CELL)

NUMBER OF PARTICIPANTS:

PLEASE CHOOSE THE TYPE OF TRAINING YOU WANT FROM THE LIST BELOW:

MOTHER AND CHILD HEALTH

NUTRITION

HEALTHY LIFESTYLE

WOULD YOU LIKE RHNP TO PROVIDE YOU OTHER SERVICES? YES NO

WOULD YOU LIKE SOME RHN SERVICES PROVIDERS TO CONTACT YOU? YES NO

DATE OF TRAINING :

TRAINING DURATION (DAYS):

OTHER COMMENTS:

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Please note that There is a special fee for organizations who seek for food demonstration