المركز الطبي الدولي
International Medical Center

الأكاديمية
The Academy

APPLICATION PARTNERSHIP FORM

Organization's Name: _____

Organization's Activities: _____

Organization's Website: _____

Organization's Official Address

Country: _____

City: _____

Po Box _____

Zip Code: _____

Name of Applicant: _____

First Name _____

Middle Name _____

Last Name _____

Email _____

Confirm Email _____

Contact Number _____

- **I hereby confirm that I have the authority to submit this application on behalf of this organization**