



REGISTRATION FORM

FILM INFORMATION	
Title	
Inclusive Date of Production	
Running Time	
Genre	<input type="checkbox"/> Documentary <input type="checkbox"/> Short film

CREW INFORMATION	
Producer/s	
Director/s	
Editor/s	
Scriptwriter	
Members	

CONTACT INFORMATION			
Representative's Name			
Complete Address			
Zip Code		Landline Number	
Mobile Number		E-mail Address	

CONFORME:

I hereby give permission for the above mentioned film/video to compete and be screened in the 1st Pharex-ACC Video Making Competition and 3rd Quisumbing-Escandor Film Festival for Health.

I have carefully read the rules and regulations of the Festival and that I agree to abide them.

I hereby authorize the organizers of the 2nd Patient Safety Congress Film Contest to screen our work/s in all the festival venues and promotions; to distribute them to them to interested persons/institutions in the country and possible abroad for education and advocacy purposes.

I hereby declare that the above information I supplied are true and correct. The organizers shall not be held liable for any tribulations resulting from the provision of false information on the above form.

I hereby declare that I/we possess all rights pertaining to my/our submitted work and I/we hereby exempt the organizers from third party claims.

SIGNATURE OVER PRINTED NAME of the DIRECTOR

DATE