

# SKYLINK TRAVEL & TOURS LTD

(ATOL 9839)

York House, Empire Way, Wembley, Middlesex – HA9 0PA. UK

Tel: 020 8902 3007 Fax: 020 8902 3011

Email: info@skylinkworld.co.uk Website: www.skylinkworld.co.uk

Date :

## Booking Form

### Kailash Mansarovar Yatra - 2012

(Please write in CAPITAL letters)

Title: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

D.O. B: \_\_\_\_\_ Nationality: \_\_\_\_\_

Address: \_\_\_\_\_

Town: \_\_\_\_\_ County: \_\_\_\_\_ Post Code: \_\_\_\_\_

Tel No.: \_\_\_\_\_ Work Tel No.: \_\_\_\_\_

Mobile: \_\_\_\_\_ Email: \_\_\_\_\_

Occupation: \_\_\_\_\_

Next to Kin Name: \_\_\_\_\_ Relation \_\_\_\_\_ Contact No: \_\_\_\_\_

Yatra Interested:  Private Kailash Mansarovar with Muktinath – 23 Days

Private Kailash Mansarovar Yatra – 18 Days

No. Of Adults: \_\_\_\_\_ Departure Date: \_\_\_\_\_ Return Date: \_\_\_\_\_

Domestic Flight Requirements: \_\_\_\_\_

Room Required:  Single  Twin  Double  Triple

Room Type:  Non-smoking  Smoking Meal Request:  Veg.  Jain

Passport Type:  British  Indian  Other \_\_\_\_\_

Indian Visa Require:  Yes  No

Special Requirements: \_\_\_\_\_

Document Required: 1) Colour Copy of Passport 2) Recent Passport size colour photograph

3) Copy of Travel Insurance

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

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## Health Questionnaire

Date :

(This form need NOT to be filled or verified by GP)

1. Diabetic :  Yes  No

If yes, more information \_\_\_\_\_  
\_\_\_\_\_

2. Blood Pressure:  Yes  No

If yes, more information \_\_\_\_\_  
\_\_\_\_\_

3. Heart Problem:  Yes  No

If yes, more information \_\_\_\_\_  
\_\_\_\_\_

4. Asthmatic:  Yes  No

If yes, more information \_\_\_\_\_  
\_\_\_\_\_

5. Arthritis:  Yes  No

If yes, more information \_\_\_\_\_  
\_\_\_\_\_

6. Knee Replacement:  Yes  No

If yes, more information \_\_\_\_\_  
\_\_\_\_\_

7. Any other health problem: \_\_\_\_\_  
\_\_\_\_\_

8. Any regular medication: \_\_\_\_\_  
\_\_\_\_\_

Disclaimer: This questionnaire is for the purpose of information only.

This is passenger's responsibility to provide us correct medical condition information.

Date: \_\_\_\_\_

Signature: \_\_\_\_\_