

## **REGISTRATION FORM**

(KINDLY PRINT OR WRITE IN CAPITAL LETTERS)

Name : \_\_\_\_\_

Age : \_\_\_\_\_ Sex : M/F \_\_\_\_\_

Designation : \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Tel : \_\_\_\_\_ Fax : \_\_\_\_\_

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

E-mail : \_\_\_\_\_

Registration Details :

Attend Conference on 6th April 2010 Yes  / No

Draft/Cheque No. \_\_\_\_\_ Bank \_\_\_\_\_

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

Mail to :

**Dr. ROBIN THAMBUDORAI**

Associate Professor & Acting Head

Department of Surgery

Christian Medical College and Hospital, Ludhiana.

**A Separate Page Can Be Appended To The Form**

\*The form can be Photocopied