

REGISTRATION FORM

Name Gender : M F

(PLEASE FILL IN CAPITAL LETTERS AS TO APPEAR IN THE CERTIFICATE)

Designation : Department* :

Hospital / Institution :

Mailing Address :

City..... Pin Code : State : Country :

*E-mail:.....

* Mobile: * Tel No Res / Off.....

- Registration Category :**
- Doctors (IAPC members) Doctors (Non members)
- Nurses, Volunteers, Students, Others (IAPC members)
- Nurses, Volunteers, Students, Others (Non IAPC members)
- Delegate's companion Workshop

Accompanying Person(s)

1. Age: 2. Age :

Kindly tick preferred Workshop*

1. EPEC India Trainers conference	<input type="checkbox"/>
2. USG Guided Palliative Care Intervention	<input type="checkbox"/>
3. Cognitive Behaviour Therapy (CBT)	<input type="checkbox"/>
4. Communication	<input type="checkbox"/>

* First come first serve basis only for 40 delegates for each workshop.

*Special workshop fee till 30th June, 2017 after that it will be INR 4000.

Registration details	Amount	Payment Details
Conference	: _____	Cheque / DD No. : _____ Date: _____
Workshop	: _____	Drawn on Bank : _____
Total	: _____	Branch : _____
		Amount in words : _____
		Date: _____ Signature _____
Note : Letter from the concerned department HOD is mandatory for all PG students for registration.		Mode of Payment : • At Par Cheque/DD to be drawn in favour of "IAPCON-2018" payable at New Delhi.

Please send the duly filled registration form and DD/Cheque (NEFT/Cash deposit receipt) at the

Conference Secretariat -

Room No. 242, Institute Rotary Cancer Hospital,
All India Institute of Medical Sciences, New Delhi, India
Website: www.iapcon2018.com

Whom to Contact -

Dr. Sushma Bhatnagar - sushmabhatnagar1@gmail.com
Mrs. Sarita Kumari - sarita.kumari1@yahoo.com
Tel.: 011-29575209

For Office use only : Receipt :

Date :

Reg No :