

REGISTRATION FORM

Title Dr Prof. Mrs. Ms.

Registration No

(As it should be in the name badge)

Name

Society

Address for Correspondence

House :.....
 Street :.....
 Post Office :.....
 City :.....
 Pin :.....
 Mobile :.....
 E-mail :.....

Official Address

Dept. :.....
 Institution :.....
 Post Office :.....
 City :.....
 Pin :.....
 Mobile :.....
 E-mail :.....

Sex Male Female Age Veg Nov. veg

PAYMENT DETAILS

	Delegates	*Post Graduates
Before 10 th July 2011	Rs. 1000/-	Rs. 500/-
After 10 th / Spot	Rs. 1300/-	Rs. 800/-

* Post graduate should get a certificate from the HOD of their institution

DD in favour of ""PERICON 2011"
 payable at KOCHI
 Bank Name.....
 Amount
 DD No.....
 Date Sign

Please mail this Form to:

CIMAR COCHIN, Unit of Edappal Hospitals P. Ltd.,
 Tipu Sulthan Road, Off NH-17, Cheranallore, Edappally, Kochi 682 034, Kerala. India
 Tel. 0484-4134444, Fax. 0484-4134455, Email: cimarcochin@gmail.com, Web:
www.cimarindia.org.