

COMPREHENSIVE INTERVENTIONAL PAIN MANAGEMENT WORKSHOP
CIPM-X

7-10th April 2016

Venue: D. Y. Patil MEDICAL COLLEGE

Registration Form

Name: Dr _____

Designation: _____ Name of the institution: _____

Address for communication - _____

City/ Pin code: _____ State: _____ Country: _____

Mobile: _____ E-mail: _____

Registration Fees Details

Date	Indian Delegates	International Delegates
Before 15 th March 2016	25000/- INR	750 USD
After 15 th March 2016	30000/- INR	1000 USD

Mode of payment: NEFT TRANSFER / Cheque / Demand draft

Amount - Rs. _____ (in words - _____)

Cash / Cheque / DD No. _____ NEFT Receipt/UTIR No – Send us by email

Drawn on (Bank Name and Branch) _____ Dated _____

Bank Details –

Account Number – 000412100061498

Payee Name - Pain Clinic Of India Pvt. Ltd. Conference account

Branch -The Bharat Cooperative Bank (Mumbai) Ltd., Near Ambedkar Garden, Chembur East, Mumbai-400071,

IFSC Code - BCBM0000005

SWIFT Code - BCBMLNBB

Please send duly filled form along with the DD/ receipt NEFT–

Dr. Kailash Kothari, Pain clinic of India, 1/1, Kandhari Colony, Rd. no.2, Opposite Hotel Orchids, Chembur East, Mumbai- 400071

Date:.....

Signature:.....

Phone - +91-9320027500 / +91-22-31908890

Website - www.painclinicofindia.com Email: cipmindia@gmail.com