ANTIBIOTIC GUARDIANSHIP WORKSHOP

In collaboration with

INDIAN COUNCIL OF MEDICAL RESEARCH

&

Hospital Infection Society India, Kolkata chapter

September 28-29 2018 | Kolkata , West Bengal

REGISTRATION FORM

(Please fill in capital letters only)

Title: ☐ Prof. ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Other __________ Gender: ☐ Male ☐ Female

Name:____

(Please write your name clearly in capital letters as the same would be used for the Certificate)

HISI Member:	Yes*	No	*If Yes, Membership No.

Medical council registration no ---------

Address:________________________________ ____

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Pin Code: _____________ Mobile: (Mandatory) _____________ Email: (Mandatory) ___________________

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The Registration Fees may be paid

By **DD/CHEQUE** favouring BELLE VUE CLINIC payable at KOLKATA to be sent along with filled Registration Form to:	**Dr. ANURADHA AGARWAL** **HOD , CLINICAL MICROBIOLOGY , HIC ,QA&I** **9, UN BRAHMACHARI STREET ,** **KOLKATA 700017** **WEST BENGAL**

DD No. ____________ Dated _____________ _ Drawn on

____

CHEQUE NO-------------------- DATED----------- DRAWN ON ____

Kindly also send scanned copies of the registration form and DD/ CHEQUE by email to bellevueclinic.quality@gmail.com