REGISTRATION FORM

Prof./Dr./Mr./Ms._____

_____

Address: _____

_____

Phone: _____ **Mobile:** _____

E-mail ID: _____

Sex: Male ☐ **Female** ☐

Are you a member of IACP: Yes ☐ **No** ☐

Accompanying persons

Name		**Age**	**Sex**
1.	**……**	**……**	**……**
2.	**……**	**……**	**……**

Total: **Rs.**

In words rupees ……

……

Demand Draft/Pay Order No. ……

Bank …… Date ……

(DD/Pay Order to be drawn in favour of NACIACP-2013 payable at New Delhi)

Signature of the delegate

Kindly mail this form to:

Conference Secretariat
Room No.4089, Department of Psychiatry
All India Institute of Medical Sciences
Ansari Nagar, New Delhi-110029
Email:naciacp2013@gmail.com
Phone: +91-11-26594412 Fax +91-11-26588663