

AICTE WORKSHOP ON MEDICAL IMAGING

Registration Form

(Use Black ink to fill the form)

Name of the Applicant (In Block Letters)[as it will appear in the certificate]

Designation: _____ Sex (M/F) _____ Highest Educational Qualification: _____

Address for Communication: _____

State: _____ PIN _____ E-mail: _____

Fax: _____ Tel: [L] _____ Mob _____

#Proof of AICTE Sponsorship Attached [form the HOD/Head of Institute] ? YES / NO

Is Accommodation required? YES / NO

Venue (Strike of the choice not applicable) KHARAGPUR / KOLKATA / ANY ONE

Name of the affiliating Institute/Organisation: _____
(In Block Letters)[as it will appear in the certificate]

Organisational contact email (optional): _____

#Details of Bank Draft of Rs 2000.00: Bank Draft No. _____

Bank: _____

Branch _____ Date: _____

#Declaration 1:

If selected, I will attend the course without failure from 2nd January to 8th January 2011 failing which the bank draft will be encashed by IIT Kharagpur.

Signature of the Applicant

Date:

#Declaration 2:

This is to certify that our institute/college/university _____

_____ is approved by AICTE and Mr/Ms/Mrs/Dr _____

_____ is fulltime employee of our institute/college/university.

Signature with seal of Head of the institute / department

* Email Address is must. All future communication will be through email.

Without the draft and declarations, no application will be processed.