

Registration Form

Title _____ Prof. Dr. Mr. Ms.

First Name _____ Last Name _____

Sex Male Female

Are you a member of IACAM Yes No

Address _____

Phone: _____ Mobile: _____

E-mail ID _____

Accompanying Persons

Name _____ Age _____ Sex _____

1. _____

2. _____

Choice of food Vegetarian Non-Vegetarian

Tick if you request for Accommodation Yes No

Payment details

For Registration Rs. _____

For Accommodation Rs. _____

Total Rs. _____

In words Rupees _____

Demand draft/Pay order number _____

Bank _____ Date _____

(DD/Pay order to be drawn in favor of Xth IACAMCON 2009 payable at New Delhi)

Signature of the Delegate

Kindly mail this form to:

Dr. Rajesh Sagar, Organizing Secretary, **Xth National Conference IACAMCON-2009**,

Department of Psychiatry, All India Institute of Medical Sciences,

Ansari Nagar, New Delhi-110029.

Category	Fee Before 31-08-09	Fee After 01-09-09
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Fellows/Members	Rs. 2,000/-	Rs. 2,500/-
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Non-Member	Rs. 3,000/-	Rs. 3,500/-
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PG Student	Rs. 1,200/-	Rs. 1,500/-
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Accompanying Person	Rs. 1,500/-	Rs. 2,000/-
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Corporate Registration	Rs. 3,000/-	Rs. 3,500/-
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Foreign Delegates	US\$ 150/-	US\$ 200/-
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(Member/Non-Member)