

Registration Form

VAICON - 2019

17th | 18th | 19th January - Visakhapatnam

12th Annual Conference of Venous Association of India

Prof. Dr. Mr. Mrs. *Name Gender : M F
(PLEASE FILL IN CAPITAL LETTERS AS TO APPEAR IN THE CERTIFICATE)

*Designation : *Department: Hospital / Institution :

Address for Communication :

*City..... State : Country : Pin Code :

*E-mail:.....

* Mobile: *State Medical Council Reg Number:

Registration Category: VAI Membership No. _____ Non VAI Member Post Graduate
 Para Medics (Nurse & Technicians) International Delegate SAARC Accompanying

Accompanying Person Name: 1. _____ 2. _____

CME + Conference Conference

Payment Details: Cheque Demand Draft Cash | Cheque/DD No: _____ Date: _____

Drawn on Bank : _____ Branch: _____ Total Amount: _____

Amount in words : _____

Date: _____ Signature _____

Mode of Payment :At Par Cheque/DD in favour of "VAICON 2019"

For online Registration and Payment Logon to www.vaicon2019.com

Please submit the duly filled form and payment to
VAICON 2019 (c/o Hallmark Events) "Maruthi ", 688, 1st floor, 6th main, 3rd block, BEL layout Vidyananyapura, Bangalore. 560097
Email: vaicon2019@gmail.com | **Ph:** 9964153557 | 9845671462

For Office use only : Receipt : _____ Date : _____ Reg No : _____