CALS COURSE REGISTRATION FORM

PERSONAL INFORMATION

Name:…….

Email address:…….

Mobile Phone Number: …….

Job Title: □Surgeon □Anaesthetist □Intensivist □Physician

□Nurse □Perfusionist □Allied Professionals

Name of Employer/Hospital:…….

Dietary Requirements:□Veg □Non-veg

Please submit filled form and payment reference to below E- Mail ID

ad.srcic@sriramachandra.edu.in

PAYMENT DETAILS

Fee(includes e-learning, course manual, lunch, taught courseand certificate):

Provider Course: □Rs.20,000 (Doctors) □Rs.15,000 (Nurses & Allied)

Trainer Course: □Rs.20,000 (Doctors) □Rs.15,000 (Nurses & Allied)

Payment method: By Bank Transfer. Please see the details below:

Bank Account of SRIHER TRUST with Indian Bank, SRU Branch

Beneficiary	-	**SRI RAMCHANDRA INSTITUTE OF HIGHEREDUCATION AND RESEARCH TRUST**
Current account No	-	**6203243021**
Bank and Branch	-	**Indian Bank, Sri Ramachandra University Branch No.1, Ramachandra Nagar, Porur, Chennai-116**
IFSC	-	**IDIB000S180**