

## Registration Form

1<sup>st</sup> Choice of date:

2<sup>nd</sup> Choice of date:

First Name :

Surname :

Date of Birth :

Residential Address:

Photo

Name of Institutions

Designation :

Tel No: Mobile :

Office :

Residence:

Email :

### Qualifications

Degree	Year	Institution	University

Medical council Registration Details :

Previous Endoscopy Training if any :

Type of Endoscopy procedures presently doing :

Kindly send the demand draft in favour of 'Cochin gynecological endoscopic and infertility training centre' payable at Ernakulam or Bank Transfer.

### Bank Transfer details

Account Name : Cochin Gynecological Endoscopic and Infertility Training Centre

Bank Name : State Bank of Travancore

Branch Name : Kathrikadavu Branch

Account No : 67258728596

IFSC Code : SBT R0000706

Nature of Account : Current Account

Swift Code : SBTRINBBFED

### Postal Address

Dr. Paul P.G,

Paul's Hospital, Kaloor, Cochin 682017, Kerala, India

Email: [drpaulpg@gmail.com](mailto:drpaulpg@gmail.com)

Ph: 91-484-2344446, 2344447

For Applicants within India (Please attach a copy of the following)

- PG Certificate
- Valid Medical Council Registration

For Applicants outside India (Please attach a copy of the following)

- Passport
- Visa
- Medical Registration details
- Report of good standing

Date:

Place:

Signature