# REGISTRATION FORM

Name (in block letters) : _____

Faculty ☐ Post Graduate Student ☐

College Address : _____

: _____

: _____

City : _____

Post Code : _____

State : _____

Country : _____

Mobile No. : _____

E-mail : _____

Telephone : _____

Registration Fees : Rs. 1000/-

**Kindly register before 15-08-2017**

## PAYMENT DETAILS

By Cheque / DD in favour of : Principal, SDM Dental College
payable at Dharwad

Cheque / DD No. No. Date:

Kindly send the Cheque/DD with the names of the delegates (in covering letter / back side of Cheque/DD)

to the following address:

Dr. Anirudh B Acharya
Organising Secretary
Dept. of Periodontics, SDM College of Dental Sciences & Hospital
Sattur, Dharwad-580009, India
Email: archeoperio2017@gmail.com Cell: 9449173973 / 9886484039

COPY OF THIS REGISTRATION FORM MAY BE USED FOR SUBMISSION

**P.T.O for select Hotel Details**
**Please note that the organising committee will not be responsible for accommodation**