Indian Association
of Colleges of Pharmacy

for a better body of knowledge

Pharmacy Practice Module - Advanced Learning Series

REGISTRATION FORM

(PLEASE FILL IN BLOCK LETTERS)

Reg. No.:

First Name:_____ Middle Name: _____ Last Name: _____

Age: _____ Gender: ☐ Male ☐ Female Nationality: _____

Institution: _____

Designation: _____ Department: _____

Address for communication:

_____ Email ID: _____

_____ CC Mail ID: _____

_____ Mobile: _____

_____ Fax: _____

Educational Qualification & Years of Teaching/Practice Experience: _____

Payment Details:

Demand Draft No.: _____ Amount: _____

Name of the Bank: _____

The Particulars given above are correct and I accept full responsibility for the same

Signature of the Applicant

Recommendation of the Head of the institute

Date:_____

Signature with Seal

Send Your Filled Registration Form Along with DD to:

Organising Committee, Indian Association of Colleges of Pharmacy,
"Prasanna Enclave", 1st Floor, No.30, Bharathi Avenue Second Street,
(Near Kotturpuram Railway Station), Kotturpuram, Chennai-600 085, Tamil Nadu, India.)

Note: **DD should be drawn in favour of 'IACP' payable at Chennai**