CMC VELLORE EQAS PROGRAM – TRANSFUSION MODULE
REGISTRATION FORM – LAB

Please take time to fill in all the details accurately in black. All fields are mandatory. All information provided will be held in confidence.
If you are an existing participant, please write your participating Pin No :

1. NAME OF LAB

2. NAME of MEDICAL OFFICER
(This will be the contact person to whom all correspondence will be addressed in future)

3. ADDRESS STREET

4.TOWN/CITY

5. DISTRICT

6. STATE

7. PIN CODE

8. TELEPHONE

STD code Telephone number

9. MOBILE

10. EMAIL ID*

11. Ownership (select one): **Government (including PSU) / Private / Private trust or Society / NGO**

12. Standalone Laboratory: **YES** **NO (Attached to a hospital)**

13. If you need a Tax invoice enter your GSTIN :