



**BAQAI MEDICAL UNIVERSITY**  
**DEPARTMENT OF**  
**CONTINUING MEDICAL / DENTAL EDUCATION**  
**(CME / CDE)**



**“WORKSHOP REGISTRATION FORM”**

**Participants Registration Data**

Receipt No: \_\_\_\_\_

Topic: \_\_\_\_\_

Name: \_\_\_\_\_ Institution: \_\_\_\_\_

Designation: \_\_\_\_\_ Department: \_\_\_\_\_

CNIC No: \_\_\_\_\_ PMDC No: \_\_\_\_\_

Cell No: \_\_\_\_\_ E-mail: \_\_\_\_\_

Date: \_\_\_\_\_ Amount: \_\_\_\_\_

BUP 5/17

Signature \_\_\_\_\_



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