



TAMIL NADU DENTAL COUNCIL

Arihant Majestic Towers, Flat No.5-0-3, No.216, J N Salai, Koyambedu Chennai – 600 107.

REQUISITION FOR APPROVAL OF CDE PROGRAMME / AWARD OF CREDIT POINTS

(FILL UP ALL THE BELOW DETAILS IN CAPITAL LETTERS (MANDATORY))

S 1. No.	PARTICULARS	ALL DETAILS ARE MANDATORY
1.	Name of the CDE provider / Institution with full address*	
2.	Name of the Contact Person	
3.	Contact Number*	
4.	Email id* (Fill in Capital letters*)	
5.	Program venue with full address*	
6.	Program date and total number of days*	
7.	a) Details of the program Topic / Duration (Details to be attached) b) Hour-wise programme and break timings required. (Details to be attached)*	Yes / No Yes / No
8.	Speaker's profile (short notes on speaker's qualifications / service / experience / paper presentations etc.,) With his / her dental registration number / name of the State Dental Council. (copy to be attached)*	Yes / No
9.	Registration Fees if any, charged from the Delegates / Participants*	Yes / No (if Yes Rs.)
10.	Brochure, if any (copy to be attached)*	Yes / No

Designation

Date

Seal of the Principal / Head
of the Organization