AMG REQUISITION FORM

Ramayamma International Eye Bank, L V Prasad Eye Institute,
Kallam Anji Reddy Campus, L V Prasad Marg, Road # 2,
Banjara Hills, Hyderabad – 500 034, India

1. **Name of the Surgeon:**

2. **Complete Postal Address (Office):**

   Phone: (STD/ISD Code):
   Mobile Number:
   Email:

3. **Year of completing Fellowship at the LVPEI:**

4. **# of AMG requested:**

5. **DD enclosed: (Yes/No)**

6. **DD particulars: (Rs 2500 Per AMG & Rs.300/- Shipping Charges)**

   DD Number:

   Date:

   Amount:

   Drawn in favour of "Hyderabad Eye Institute":

Signature: **Date:**

-------------------------------------FOR OFFICE USE ONLY-----------------------------------

Lot No: ____________________ # of Vials______________ Date Sent _______________

Email: rieb@lvpei.org Fax: 040 – 23548271 Phone: 040 – 30612 514