TRAVEL REIMBURSEMENT / CLAIM FORM

(To be filled by the Delegates/Speaker)

NAME OF EVENT: "International Patient Summit 2023"

VENUE : "The Radisson Blu Hotel, Plot no 4, Sector 13, Dwarka New Delhi-110075"
DATE & TIME : "11th & 12th December 2023, Time: - 9:30AM to 5:30PM"

1. Participant's Name: _____
2. Indicate Whether: ☐ Delegates ☐ Speaker
3. Address of Participant: _____
   _____
4. Name of the Organisation: _____
   _____
5. Address of the Organisation: _____
   _____

Direct Deposit Payment Information:

Account Holder's Name: _____

Account Number: _____

IFSC Code/IBAN/SWIFT: _____

Bank Branch and Address: _____

_____

Detail of Claims

A) Fare (Attach Photocopy of Tickets) USD/Rs. _____

B) Local Travel

C) Travel insurance USD/Rs _____

TOTAL USD/Rs. _____

USD/Rupees:_____

Signature of Applicant **Approving Authority**