

# UP STATE MEDICAL FACULTY, LUCKNOW

## REMUNERATION BILL

NAME OF THE EXAMINER

NAME OF TRAINING CENTER (Examiner Belongs)

FULL POSTAL MAILING ADDRESS

MOBILE NUMBER

NAME OF THE EXAMINATION

MONTH & YEAR OF THE EXAMINATION

NAME OF EXAMINATION CENTER

DATE OF THE EXAMINATION

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SUBJECT

NUMBER OF PAPERS / CANDIDATES -

PAPER SETTING @ RS 1500 each

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Note: Form to be filled in Capital Letters only.

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