TATA MEMORIAL CENTRE
DEPARTMENT OF CANCER CYTOGENETICS
EXTERNAL QUALITY ASSURANCE SCHEME

APPLICATION FOR REGISTRATION

Name of the Laboratory/ Institute:

Address:

Pin Code:

Email ID:

Annual workload in Cytogenetics: *FISH:* *Karyotyping:*

Staff Strength in Cytogenetics: *Technical staff:* *Cytogeneticists:*

List of tests included in Hematological Malignancies-

Accreditation Status: Accredited / Not Accredited

Accredited by: (Please enclose a copy of the accreditation certificate)

NABL /CAP / Others (Specify_____)

Contact person / Authorized signatories:

Name	**Designation**	**Experience in Cytogenetics (in years)**	**Email**	**Mobile / Phone No:**

Payment details: NEFT UTR:_____ **AMOUNT PAID:_____**

Signature, Date and Stamp: