

AMG REQUISITION FORM

**Ramayamma International Eye Bank, L V Prasad Eye Institute,
L V Prasad Marg, Road # 2, Banjara Hills, Hyderabad - 500 034, India**

1. **Name of the Surgeon:** -----

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

Fax: -----

Phone: -----

Email: -----

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

4. **# of AMG requested:** -----

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

6. **DD particulars:**

DD Number: -----

Date: -----

Amount: -----

Drawn in favour of Hyderabad Eye Institute: (Yes/No)

Signature: -----

Date: -----

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

Lot No: _____ **# of Vials** _____ **Date Sent** _____

Email: rieb@lvpei.org **Fax:** 040 – 23548271 **Phone:** 040 - 23548266