



# JOURNAL OF OROFACIAL RESEARCH

E-39, 45 BUNGALOW, | BHOPAL-462003, MADHYA PRADESH, INDIA

PHONE: +91 755 4005126 | FAX: +91 755 4005342 | Email: editor@jofr.in | Website: www.jofr.in

←-----  
-----→

**Manuscript Title:**

---

---

**1<sup>st</sup> Author Name:** \_\_\_\_\_.

## **COPYRIGHT TRANSFER:**

I/we certify that I/we have participated sufficiently in the intellectual content, conception and design of this work or the analysis and interpretation of the data as well as the writing of the manuscript, to take public responsibility for it and have agreed to have my/our name listed as a contributor. I/we believe the manuscript represents valid work. Neither this manuscript nor one with substantially similar content under my/our authorship has been published or is being considered for publication elsewhere, except as described in the covering letter. I/we certify that all the data collected during the study is presented in this manuscript and no data from the study has been or will be published separately.

In consideration of the acceptance of the above work for publication, I/We do hereby assign and transfer to “Journal of Orofacial Research” all rights, title, and interest in and to the copyright in the above titled work.

I/We give the rights to the corresponding author to make necessary changes as per the request of the journal, do the rest of the correspondence on our behalf and he/she will act as the guarantor for the manuscript on our behalf.

All persons who have made substantial contributions to the work reported in the manuscript, but who are not contributors, are named in the Acknowledgment and have given me/us their written permission to be named. If I/we do not include an Acknowledgment that means I/we have not received substantial contributions from non-contributors and no contributor has been omitted.

Each author warrants that he or she has no commercial associations (e.g., consultancies, stock ownership, equity interest, patent/licensing arrangements, etc.) that might pose a conflict of interest in connection with the submitted article, except as disclosed on a separate attachment. All funding sources supporting the Work and all institutional or corporate affiliations of the authors are acknowledged in a footnote in the Work.



When reporting experiments on human subjects, indicate whether the procedures followed were in accordance with the ethical standards of the responsible committee on human experimentation and with the Helsinki Declaration of 1975, as revised in 1983. Do not use patients' names, initials, or hospital numbers, especially in illustrative material. Papers including animal experiments or clinical trials must be accompanied by an approval by the local ethics committee.

**CONFLICT OF INTEREST DISCLOSURE:**

All institutional or corporate affiliations of mine and all funding sources supporting the work are acknowledged. Except as disclosed in the separate enclosed letter, I certify that I have no commercial associations (eg, consultancies, patent-licensing arrangements, equity interests) that might represent a conflict of interest in connection with the submitted manuscript (letter attached).

**Co Authors (Name & Signature):**

1. 2<sup>nd</sup> Author signature \_\_\_\_\_ Print name \_\_\_\_\_
  
2. 3<sup>rd</sup> Author signature \_\_\_\_\_ Print name \_\_\_\_\_
  
3. 4<sup>th</sup> Author signature \_\_\_\_\_ Print name \_\_\_\_\_
  
4. 5<sup>th</sup> Author signature \_\_\_\_\_ Print name \_\_\_\_\_
  
5. 6<sup>th</sup> Author signature \_\_\_\_\_ Print name \_\_\_\_\_

Each author must read and sign the following statements; if necessary, photocopy this document and distribute to coauthors for their original ink signatures. Completed forms should be submitted to the Editorial Office. Or after signature, scan it and sent via email: editor@jofr.in



## JOURNAL OF OROFACIAL RESEARCH

### **Manuscript Processing Fees:**

The processing fee of Rs.2500/- will be charged if your manuscript is accepted for publication in our journal. You have to send a DD in Name of **Dr. N. S. Yadav**, payable at Bhopal and sent to the journal home address.

DD No. \_\_\_\_\_, Amount \_\_\_\_\_, Bank \_\_\_\_\_

Date \_\_\_\_\_, Place \_\_\_\_\_.

Or for online Deposit: Name: Dr.N.S.Yadav, Bank Name: State Bank of India. Account Number: 30565204022. RTGS/NEFT IFSC code: SBIN0010143. Branch: Bhopal Memorial Hospital and Research Center (BMHRC). Bhopal. M.P

**Corresponding Author (Name & Signature):** \_\_\_\_\_

Date: