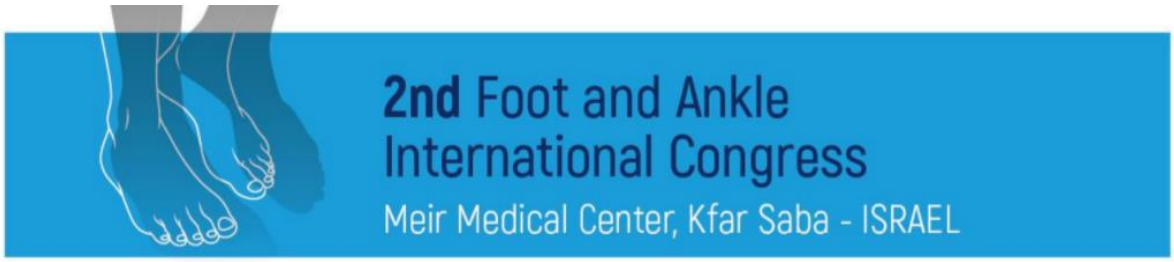


Registration form:

(in English please)

Title: Prof ○ Dr ○ Mr.○ Mrs.○ Ms.○

First name: _____

Last name: _____

Hospital: _____

City: _____

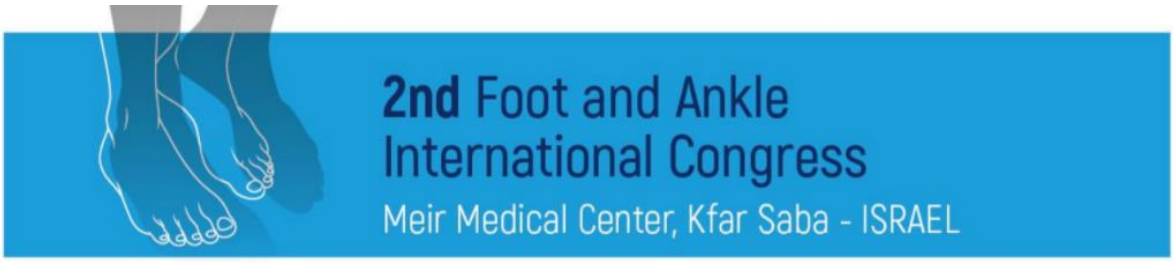
Country: _____

Profession: Orthopedic physician ○ Non- orthopedic physician ○ Resident ○

Nurse ○ Physiotherapist ○ Medical Industry ○ Other ○ _____

e-mail: _____@_____

Phone: _____



CONGRESS REGISTRATION FEES (early registration)

◯ Physician 300 NIS

◯ Residents in training, Physiotherapist, Nurse 200 NIS

◯ **Payment by credit card. With my signature I authorize Meir Medical Center to charge my credit card**

◯ **Visa** ◯ **American Express** ◯ **Eurocard/Mastercard**

Card Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

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Expiry Date: ☐☐ / ☐☐ / ☐☐ **DD/MM/YY.**

CCV: ☐☐☐☐ *** if You wish we can call you back to complete the CCV.**

Please send the Registration Form:

- **E-mail:** registration@footandanklecongress-israel.com
- **FAX: (+972)9-7471746**