A14_030 REGISTRATION FORM

Surname ______________________________ Name ____________________________________

Hospital _______________________________ Dept. ______________________________________

Address ____

City _____________________ Country _____________________________ ZIP Code ______________

Phone _________________ Fax __________________ Email _______________________________

Invoice information (mandatory)

Name / Company name _______________________ Address _______________________________

City _______________ Country _____________________________ ZIP Code ___________________

Fiscal Code (if owned) ________________________ VAT Number (if owned) _______________________

REGISTRATION FEE (VAT 22% EXCLUDED)

☐ **Euro 500,00 Medical Doctor** ☐ **Euro 200,00 Student** ☐ **Euro 150,00 Nurses**

PAYMENT MODALITIES:

☐ **Bank transfer** to **M.A.F. Servizi srl within November 7th**

Banca Generali - Bank account payable to: MAF SERVIZI SRL

IBAN: IT 46 Q 03075 01603 CC8000314426 **(please include a copy of bank transfer)**

reason for payment: A14_030 - surname_name

☐ **Credit Card** (Only Visa and/or Mastercard will be accepted)

☐ Visa ☐ Master Card

The undersigned _____________________________________ authorize M.A.F. Servizi Srl, to charge Euro __________ /00 on the Credit Card

N __/__/__/__/ __/__/__/__/ __/__/__/__/ __/__/__/__/

Expiry date ____________

Security Code CVV2 (3 digit code printed on the back of your credit card) ___________________________

Registered to ________________ Date of birth ___/___/____

I declare that I have read and accepted the above conditions

Date ___/___/_____ Signature __________________________

PRIVACY

☐ The following signature involves the complete matter acceptance and authorizes M.A.F. Servizi srl. To utilize your personal data as Italian Privacy Lay 196/2003.

NB: In absence of such approval it will not be possible to register to the event.

Date _____/______/____ Signature ____________________