Registration Form

First Name(s):________________________Middle :_______________________Family :_________________

Title: ____

Specialty:____

Faculty/Institution/ Hospital: ____

Nationality:____

Address: ____

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Tel: ____________________________________Fax:____

Cellular:__________________________________E-mail:_______________________________________

Total amount to be paid: ____

N.B.: No registration will be accepted without the registration form fulfilled and presented with the registration fees.

This form should be FAXED to Organizing office in charge:

ICOM International Center for Organization & Marketing
Tel : +203-4204849 +203-4249072 Fax. : +203-4204849
Cellular: + 012-2480206 +010 – 122 4849 E- mail :icom@dataxprs.com.eg