



Ordine dei Medici e Chirurghi e
Odontoiatri della Provincia di Nuoro



REGISTRATION FORM

Use one form per person.

Please use BLOCK CAPITALS to fill in this form and send it by fax or by e-mail to the Organizing Secretariat Kassiopea group Srl, Via Mameli 65 – 09124 Cagliari – fax number +39 070 656263 – e-mail address simonacasu@kassiopeagroup.com **no later than 10th September 2010**

WORK ADDRESS

Mr

Ms

Dr

Prof

Surname

First name

Telephone n°

e-mail

Address

City

ZIPcode

State/Province

Country

University/Institute/Hospital/Company/Other

Department/Division/Other

HOME ADDRESS

Address

City

ZIPcode

State/Province

Country

Telephone n°

Fax n°*

e-mail*

*This is a mandatory field in order to send the registration confirm.

REGISTRATION FEE - € 250,00 (VAT included)

Registration fee includes: participation in all scientific sessions, attendance certificate, CME credits, conference kit, lunches and coffee breaks.

CONFIRMATION OF REGISTRATION

A written confirmation of registration status will be sent by the Organizing Secretariat after receiving the registration form and the corresponding payment.

CANCELLATIONS

Cancellations must be notified by fax or e-mail to the Organizing Secretariat.

Refunds will be made 60 days after the conclusion of the congress as follows:

- For cancellations received by 15th September 2010, a refund of 50% of the paid amount will be made
- For cancellations received after 15th September 2010, no refund will be made





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PAYMENT METHOD

Bank Transfer to:

Kassiopea Group srl
Bank address: UNICREDIT BANCA DI ROMA – L.go Carlo Felice, 27 - 09124 Cagliari, Italy
Account number: 000010070053
SWIFT Code: BROMITR1H60
IBAN Number: IT 08 C 03002 04810 000010070053

Please specify the name of the Participant and the payment description in the bank transfer object: registration to the “Su Gologone Symposia”

(A copy of bank transfer must be enclosed)

Please note that all transfer expenses must be assumed by the sender.

Credit Card

I authorize Kassiopea Group srl to charge my credit card														
<input type="checkbox"/> VISA <input type="checkbox"/> CARTASI <input type="checkbox"/> MASTERCARD														
Total charge € 250,00														
Cardholder name														
Surname										First name				
Card Number										Expiration Date				
Signature														

INVOICING Heading* Billing address* VAT number* Shipping address (if different from billing address)*

*Mandatory fields in order to proceed with the Registration at the event.

In compliance with Leg. Decree no. 196/2003 and with regards to the processing of the personal data indicated on this form, we inform all participants that your personal information will be included in our database and processed exclusively for purposes related to this Conference. These data shall not be transferred to third parties.

Failure to authorize the processing of personal data compromises this fulfillment.

By signing this form, the signer declares that is aware of the contents of art. 13 of Leg. Decree 196/2003 and in particular, of the purposes and methods of data processing and any other detail foreseen by the above mentioned law.

Date

Signature