

Personal information

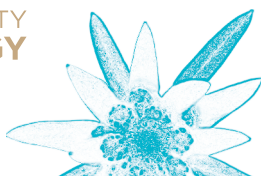
Title:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
First Name*:		Last Name*:	
Date of birth*:		Profession*:	
Hospital/Institute:			
Department:			
Street/No.:			
ZIP Code*:	City*:	Country*:	
Phone:		Fax:	
E-mail*:			

* required

Registration details:

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* Please send a written confirmation signed by your head of department to verify your current professional status via e-mail to registration@myESR.org.



Payment details

Bank transfer (bank details will be sent to the indicated e-mail address)

Credit card: Visa Eurocard/Mastercard

Credit card number

Expiry date CVC

Name of cardholder: _____

Date: _____

Signature
of cardholder: _____

Important information:

Kindly note that this special reduced offer is only available if the completed registration form is sent to the ESR Office either via e-mail (registration@myESR.org) or fax (+43-1-5334064-444) by

Please make sure your e-mail address is clearly legible.

If you chose payment by bank transfer, an e-mail containing the payment details will be sent to you in early September 2017 when the online registration officially starts. Once the registration payment is completed or a regular registration has been completed beforehand, there will be no possibility of a refund. I hereby agree with the terms and conditions of ECR 2018 (to be found at www.myESR.org).

_____ Date

_____ Signature