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Please select workshop date:

24. - 25.10.2019
 (UFE/PAE)

Registration Form
Center of Excellence - Vienna

Venue: Hotel Stefanie, Taborstr. 12, 1020 Vienna
 Krankenhaus der Barmherzigen Brüder Vienna, Radiologie und Nuklearmedizin,
 Johannes-von-Gott Platz 1, 1020 Vienna

Participant (Please fill in legibly in print letters):

Salutation / Title	First given name	Surname
Institution		Department
Profession: <input type="checkbox"/> Radiologist <input type="checkbox"/> other (please specify):		Training / Degree (e. g. in-training, practice, ...)
Address		ZIP code, city
Phone / FAX		e-mail address

Participation in the get-together Dinner <input type="checkbox"/> Yes I will join <input type="checkbox"/> No, I will not join	Transfer from the Hotel to the Dinner Restaurant and back <input type="checkbox"/> Yes, I will join <input type="checkbox"/> No, I get there on my own
Special Food requirements for the Dinner : <input type="checkbox"/> Regular Menu <input type="checkbox"/> Meat only <input type="checkbox"/> Fish only <input type="checkbox"/> Vegetarian Menu <input type="checkbox"/> Allergies/spec. Requirements:	

Housing:

We have reserved hotel rooms at **Hotel Stefanie****** at preferential rates of about € 119,-/night (single room, breakfast included). The amount of the hotel reservation will be debited from my bank account / credit card (see below).

Reservation <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> single room <input type="checkbox"/> double room (price on request; name of the companion: _____)
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Registration fee:

This registration is binding. A registration fee of € 150 applies. Registration fee includes workshop participation, hands-on training, on-site catering on Friday and Saturday during the workshop and the get-together dinner incl. Transfer on Friday evening. In case of cancelation, a cancelation fee of € 20 applies. The registration fee of € 150 will be debited from my bank account / credit card as stated:

Please debit the indicated participation fee from **my bank account**:

Bank name	IBAN
BIC	account owner (if different to the participant)

Please debit my **credit card** with the registration fee:

Card type	Credit card number	Valid until:
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The workshop will be sponsored by Merit medical. I hereby agree that my name and address data will be passed to the sponsor in order to verify the proper use of the sponsoring. Mit Ihrer Anmeldung bestätigen Sie unsere allgemeine Datenschutzerklärung sowie die „Datenschutzerklärung für Kongressanmeldungen“ gelesen und akzeptiert zu haben.

Place, Date

Signature