

# REGISTRATION FORM

## SZUSICON 2009

### 1. Participation information

Title (prefix): Prof  Dr.  Mr.  Ms.

Name: \_\_\_\_\_

Institute: \_\_\_\_\_

### Mailing Address:

Office: \_\_\_\_\_ Res: \_\_\_\_\_

Country \_\_\_\_\_

Tel \_\_\_\_\_

Fax \_\_\_\_\_ Mobile: \_\_\_\_\_

Email: \_\_\_\_\_

Doctors

Nurses

Medical Students

Accompanying Person

### 3. Accompanying person (s)

Name: \_\_\_\_\_

### 4. Mode of Payment

Mode of Payment	Total Amount	Drawn At	Dated
Demand Draft			

Date:

Signature

Please send this registration form via mail or fax to **SZUSICON 2009** Secretariat  
Dr. ShriShailesh Amarkhed Organising Secretary, SZUSICON 2009 KLES Kidney Foundation,  
KLES Dr. Prabhakar Kore Hospital & Medical Research Centre, Nehru Nagar, Belgaum. 590 010, Karnataka