American Healthcare Professionals and Friends for Medicine in Israel
2001 Beacon Street, Suite 210, Boston, MA 02135

POST FELLOWSHIP REGISTRATION FORM

*As per your **Fellowship Agreement** with APF you have agreed to return to Israel within 3 months after completion of your Fellowship.*

INSTRUCTIONS: After you return to Israel please send back this form to update your contact information.

NAME: _____

HOME: _____
(Number and Street) Apt. No.

City_____ Postal Code_____

Telephone ( ) _____ Cell ( ) _____

E-Mail _____

WORK: _____
(Institution/Department)

SPECIALTY: _____

_____
(Number and Street)

City_____ Postal Code_____

Telephone ( ) _____ E-Mail _____

Signature _____ Date _____
by signing above, I confirm my return to Israel