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

Registration

APF's Podiatric Scientific Mission in Israel

November 15th - November 24th, 2015

Name (as it appears on your Passport): _____

Mailing Address (including City, State, and Zip code): _____

_____

Phone (including area code): (H) _____ (W) _____

E-Mail: _____

Specialty: _____ Date of Birth: _____

Passport Number (required for admission to some sites): _____

Passport Expiration: _____
(Please note that passport must be valid for a minimum of 6 months after entry into Israel)

_____ Please reserve a single room _____ Please reserve a double room

I shall be sharing a room: Circle one of the following: Participant, Spouse Participant or Non-Participant

Accompanying Person's Name: _____

Specialty (if necessary): _____

Passport Number: (required for admission to some sites): _____

Expiration Date: _____ Date of Birth: _____
(Please note that passports must be valid for a minimum of 6 months after entry into Israel)

In case of emergency please contact (include relationship, address and phone):

_____

_____

Credit card information number: _____ Exp.: _____

Signature: _____ I agree to pay according to card issuer agreement

Please return this form with your $500 deposit.
Check, Credit Card or Online payments accepted (Make checks payable to APF)