



## REGISTRATION FORM

### “APPLIED SCIENCE FOR THE CARDIO-THORACIC SURGEON” 23-25 March 2006, Prague, Czech Republic

**REGISTRATION DEADLINE – 01 MARCH 2006**

Family Name _____	First Name _____	Title: Dr/Mr./Ms _____
Department _____	Hospital _____	
Address _____		
City _____	Post Code _____	Country _____
Email (All correspondence will be by email) _____		
Tel (inc Country Code) _____	Fax (inc Country Code) _____	

### REGISTRATION PACKAGES

N.B. – Course fee includes lunch, refreshments throughout the course and Dinner on Friday evening.

Option	Includes	Price €(Euro)	Please indicate your choice
1	Course Fee	75.00	
2	Course Fee + Shared 3* Hotel Accommodation adjacent to the University for 3 nights (22, 23, 24 March 2006)	175.00	
3	Course Fee + Single 3* Hotel Accommodation adjacent to the University for 3 nights (22, 23, 24 March 2006)	250.00	

Special Dietary Requirements: \_\_\_\_\_

Payment can be made by credit card or bank transfer. Scholarships may be available to those whose institutions cannot cover the cost.  
(Scholarships will cover the cost of Options 1 & 2 only.)

#### Credit Card (Amex, Visa, Mastercard)

Credit card number \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Expiry date \_\_\_\_ / \_\_\_\_

Name on card \_\_\_\_\_

Cardholder signature \_\_\_\_\_

#### Bank Transfer:

To help us identify your payment, please mention the delegate name and 'Applied Science Course' on your transfer. The transfer **must be exempt of charges** to EACTS Trading Company Ltd.

Name of Bank: Royal Bank of Scotland, London Belgravia Branch, 24 Grosvenor Place, London, SW1X 7HP

Account: EACTS Trading Company Ltd Account Number: 10020440

Bank Code: 16-10-70 Swift code: RBOSGB2L

IBAN No.: GB81 RBOS 1610 7010 0204 40

**CHEQUES ARE NOT ACCEPTED.**

#### I will apply for a Scholarship and have Certification from Head of Department

Family Name _____	First Name _____	Title: Dr/Mr./Ms _____
<b>I Certify that the Applicant works as a trainee in my department and that this institution cannot cover the cost of the course.</b>		
At (Hospital/Institution) _____		
Email _____		
Tel (inc Country Code) _____	Fax (inc Country Code) _____	
Signature _____		

I note that I have to bring a laptop computer with me to participate in this course.

DELEGATE SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

PLEASE RETURN THIS FORM TO THE EACTS SECRETARIAT.

EMAIL: [registration@eacts.co.uk](mailto:registration@eacts.co.uk) FAX: +44 (0) 1753 620407 MAIL: 3 Park Street, Windsor, Berks SL4 1LU, UK