Form A

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The 5th Asian Congress of Oral and Maxillo-Facial Radiology

REGISTRATION FORM

Title ☐ **Prof./** ☐ **Dr./** ☐ **Mr./** ☐ **Mrs./** ☐ **Ms.**

Name _____ _____ _____
First **Middle** **Family Name**

Affiliation: _____

Mailing address: ☐ **Home** ☐ **Office**

_____

_____ _____ _____
Country **Post Code**

Tel: _____ **Fax:** _____

E-mail: _____

Accompanying Person(s)

☐ **Mr.** ☐ **Ms.** _____ _____ _____
First **Middle** **Family Name**

☐ **Mr.** ☐ **Ms.** _____ _____ _____
First **Middle** **Family Name**

	Pre-Registration on or before 30/09/04	On-site Registration (after 30/09/04)	No. of person(s)	Amount to be paid
Participant	US$ 200	US$ 250		US$
Student	US$ 100	US$ 150		US$
Accompanying Person	US$ 100	US$ 150		US$
			Total Amount	US$

Payment of registration fees should be paid in US$ by Bank transfer to: **"The 5th Asian Congress of Oral and Maxillo-Facial Radiology"**

Mailing Address:

Dr. Onanong Chai-U-Dom, Secretary General
The 5th Asian Congress of Oral and Maxillo-Facial Radiology
Department of Radiology, Faculty of Dentistry
Chulalongkorn University
Henri-Dunant Rd., Wangmai, Pratumwan
Bangkok 10330, THAILAND

TEL: 662-218-8782 **FAX: 662-218-8780** **E-mail: onanong.c@chula.ac.th**

Signature: _____ **Date:** _____

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