

**REGISTRATION FORM**

Receipt No.: 2019-001-\_\_

**COMPLETE NAME (To be printed on the Certificate)**

**TITLE:** Dr. Prof. Mr. Mrs. Miss Others **GENDER:** Male Female

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| **REQUIRED: Saudi Commission for Health Specialties License No. (1.e. 06-R-N-12345):** | |
| Institution/Hospital: | |
| Profession: | Telephone |
| Email Address: | Fax: |
| City/Postal Code | Mobile |
| Mailing Address/MBC: | |

**Contact Information:**

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Congress Secretary

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E-mail: [carlamercado@kfshrc.edu.sa](mailto:carlamercado@kfshrc.edu.sa)

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**PAYMENT RECEIPT**

Receipt No.: 2019-001-\_\_

**Registration fee:** (*Cash Only; Onsite payment*)

Surgeons, Physicians, GP and Allied Health - **400 SR**

Students, Residents, Fellows – **Free\*** (\*Registration deadline 24 March 2019)

Received from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SR

Payment for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Received by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_