**Please send or fax to +49 (0)931 / 201-21248**

**Department of Otorhinolaryngology**

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**Conference Registration form (*Application is not submitted electronically)***

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| **Congress secretariat:**Department of OtorhinolaryngologyUniversity of WürzburgCaroline BinderJosef Schneider Str. 11D-97080 Würzburg, GermanyPhone: +49 (0)931 / 201-21701Fax: +49 (0)931 / 201-21248🖳: binder\_c@ukw.de**www.hno.ukw.de****Course fees:****Early bird rate until Dec. 31st, 2016:**300 € Course fee;add. 220 € per session (180 min.) for temporal bone exercises **Standard rate from January 1st, 2017:** 350 € Course fee;add. 250 € per session (180 min.) for temporal bone exercises **Confirmation letter:**A confirmation letter will be sent upon receipt of your registration form.Please inquire if confirmation does not reach you 2 weeks after your sending.**Bank transfer:**Please transfer your registration fee to the congress bank account **after receipt of confirmation:****Recipient:** Würzburg University Clinic **IBAN:** DE73 7905 00000044610582 **BIC (Swift Code):** Byladem1SWU; **Banking institution:** Sparkasse Mainfranken Würzburg **Notation for remittance:** “ENT Department, account 8601467”, and additional your subscriber numberPrecondition for participation in the temporal bone exercises is remittance **within two weeks after receiving our confirmation.** A processing fee of € 25 will be retained on all cancellations. Refunds will not be issued for cancella-tions after January 31st, 2017.  | **Registration****I. Participation** 🗷 in the 29th Course on Microsurgery of the Middle Ear **II. Individual subscription (please mark with a cross):**[ ]  Participation in the temporal bone exercises (one session about  180 min.) [ ]  Beginner [ ]  Professional[ ]  I am interested in a second training session on Wednesday 22nd (in case of available places) [ ]  Participation in the social program on Monday, February 20th at the Staatlicher Hofkeller Würzburg (included in the course fee);  Add. participant(s) (40 €): \_\_\_\_\_\_ **III. Participant** (Please print your name as you wish it to appear on your badge) [ ]  Prof. [ ]  Dr. [ ]  Mr [ ]  Mrs [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Family Name: First Name: Affiliation: Street + number: Postal code/City: Country: Work phone: ( ) Work fax: ( ) Email: @ Dietary requirements: **Date: Signature: \_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |