

*The 1st Russell Berrie
International Diabetes Symposium 17-19 October, 2004
Jerusalem Renaissance Hotel
Jerusalem, Israel*

Last Name: _____
First Name: _____
Institution: _____
Address: _____

Post Code: _____
City: _____
Country: _____
Phone: _____
Fax: _____
Email: _____

Hotel Accommodation

Arrival Date: _____
Departure Date: _____
Number of Nights: _____

Total payment for the participation in the symposium including payment for 3 nights 17-19 (breakfast, lunch and coffee during coffee breaks on the 18th and the 19th of October) in Jerusalem Renaissance Hotel: \$550

Form of payment

Credit Card: _____
Number: _____
I.D. _____
Validity: _____
Total: _____

Check should be made out to the account of: Israel Diabetes Association

Total: _____ Please attach registration form to the check and mail to:
Israel Diabetes Association
46 Derech Ha'Maccabin St.
75359 Rishon Le'Zion
Israel

Persons registering should indicate whether they would like to receive Continuing Medical Education (CME) certificates from the Hebrew University Hadassah Medical School

Please print the form and send by fax: 972-3-9508111

Registration Form for Guest Participants
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