

12th PRAGUE WORKSHOP ON CATHETER ABLATION

April 5 – 7, 2009, Prague, Czech Republic

REGISTRATION FORM

Title _____ First Name _____ Last Name _____
Hospital / Institute / Company _____
Department _____ Position _____
Mailing Address _____
City _____ Country _____
Phone _____ Fax _____ e-mail _____

REGISTRATION

Up to February 5, 2009

- 250 EUR
 1000 CZK – CKS members

From February 6, 2009

- 300 EUR
 1500 CZK – CKS members

I am interested in an active participation in the Workshop YES NO

My presentation / case report title:

Co-authors: _____

HOTEL REQUEST

Arrival Date _____ Departure Date _____

HOTEL: TOP Hotel Praha **** Vladar **** Emmy Residence **** Gradient ***

2nd choice: _____ (if requested hotel is booked)

Special requirements _____

Room type: single
double with spouse
one bed in double Room Mate _____

Full prepayment of the registration fee as well as the accommodation is required. Please advise the way of payment you will use:

- bank transfer – EUR account No. 1066072036/2700 with UniCredit Bank Czech Republic a.s., swift code BACXCZ PP, IBAN 192700000001066072036 (please attach copy of bank transfer document)
 bank transfer – CZK account (payments from Czech Republic only) 1066072001/2700 with UniCredit Bank Czech Republic a.s. (please attach copy of bank transfer document)
 credit card

Type of credit card:	Visa	Eurocard	Mastercard	American Express	
Cardholder's name:					
Card number:				Expiry date:	
Cardholder's signature:				* Card validation code:	

* last 3 digits in the signature stripe on the reverse side of credit card (Visa, Eurocard, Mastercard), or 4 digits above the card number (American Express)

Registration forms as well as payments should be addressed to:

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fax: +420-220 516 834
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Date

Signature