

Advanced Techniques in Cervical Spine Decompression & Stabilization

HANDS-ON DISSECTION COURSE

Center of Biotechnologies of Cardarelli Hospital
Naples, September 20th-22nd, 2017

COURSE DIRECTOR
Giuseppe Barbagallo, MD
Associate Professor of Neurosurgery
Chairman, Neurosurgical Department
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Vincenzo Albanese, MD

HONORED GUEST
Dan Riew, MD

SCIENTIFIC SECRETARIAT
Francesco Certo
Giuseppe Roudino
Gaspere Francesco Montemagno



Course reserved up to 14 attendees

OFFICIAL LANGUAGE ENGLISH

EDUCATIONAL METHODS

7 hours of interactive theoretical and demo sessions
7 hours of practical training step by step on wet lab



Organizing Secretariat My Meeting

REGISTRATION FORM

To be completed in block letter and sent with payment to My Meeting S.r.l.
info@mymeetingsrl.com

The course has a limited enrolment: 14 attendees + 7 observers

Registration will be handle accordingly with the first-come, first served system.

Deadline for registration September 8th, 2017

PROFESSIONAL ADDRESS

Surname _____ Name _____

Hospital/Institution _____

Department _____ Role _____

Address _____

Zip Code _____ City _____

Country _____ State _____

Ph. _____ Fax _____

E-mail _____ Mobile _____

PRIVATE ADDRESS

Private address _____

Zip Code _____ City _____

Country _____ State _____

COMPULSORY FOR ALL PARTICIPANTS

Invoice made out to: _____

Address _____ Zip code, City, Country _____

TAX n° _____ VAT n° _____

e-mail to send the invoice _____

RISERVATO ALLE ASL E AZIENDE OSPEDALIERE

In caso di richiesta di emissione fattura nei confronti di enti esenti IVA (A.S.L./A.O.) il partecipante dovrà farne richiesta al momento dell'invio della scheda di iscrizione. La A.S.L./A.O. è tenuta a inviare a My Meeting l'autorizzazione nominativa del partecipante al corso e tutti i dati necessari all'emissione della fattura elettronica (**codice univoco**); Il pagamento della quota esente IVA dovrà essere effettuato vista fattura.

REGISTRATION FEE: Attendee, Resident and Fellows° € **1.500,00** VAT included
Observer € **500,00** VAT included
°Proof must be provided by the Director of the Program

SUMMARY OF PAYMENT: REGISTRATION FEE € _____

TOTAL PAYMENT: € _____

• HOW TO PAY

Credit card total amount € _____ VISA EUROCARD MASTERCARD

Card Number _____ Expiry date __ / __ Security Code ___ (3 digits on the back of the card) Holder's name _____ Signature _____

Bank Transfer, made to the order of the following account: in favour of **My Meeting S.r.l.** - Description "L14 Cervical Spine Hands-on + name and surname"
Bank CARISBO Cassa di Risparmio in Bologna Filiale San Lazzaro (BO) via Jussi 1 - Account n° IBAN: IT 13 Y 06385 37070 100000006418 - SWIFT-BIC Code: IBSPIT2B.

With reference to the information on private data provided in the "General Information" section of the Meeting Program. I hereby give my consent to the processing of my personal data, according to Legislative Decree no. 196/2003.

Date _____ Signature _____