

____(naslov srečanja)_____

**Ljubljana,
SEKCIJA/ZDRUŽENJE**

Name and surname:	
Specialist / Specializant / drugo:	
Home address:	
Employer / Institution:	
Department:	
Phone nr.:	
E-mail:	

PAYMENT DETAILS

Payer's name:	
Payer's address:	
Payer's VAT nr.:	
Payer's stamp and signature:	

REGISTRATION FEES (mark)

- **PHYSICIANS: 150 EUR**
- **TRAINEES: 100 EUR**
- ***COURSE OF MINIMALLY INVASIVE PEDIATRIC SURGERY: 50 EUR(MAX 12 participants)***
- **MEDICAL STUDENTS / RETIRED PHYSICIANS: 20 EUR**
- **NURSES: 60 EUR**
- **ACCOMPANYING PERSONS: 50 EUR**

Date:	

Please print, fill out, scan and email to:
E-pošta: _____

