

A Clear Vision for Radiology

REGISTRATION FOR ECR 2020,
MARCH 11-15

REDUCED REGISTRATION FEE

Personal information

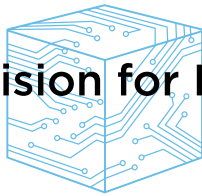
Title:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
First Name*:		Family Name*:	
Date of birth*:		Profession*:	
Hospital/Institute:			
Department:			
Street/No.*:			
ZIP Code*:	City*:	Country*:	
Phone:		Fax:	
E-mail*:			

* required

Registration details:

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*Please send a written confirmation signed by your head of department/hospital or professional representative body to verify your current professional status via e-mail to proof@myESR.org.



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Payment details

- Bank transfer
- Credit card: Visa Eurocard/Mastercard

Important information:

Kindly note that this special reduced offer is only available if the completed registration form is sent to congress@myesr.org **until October 17, 2019** at the latest.

Please make sure your e-mail address is clearly legible.

An e-mail containing the payment details will be sent to you. Once the registration payment is completed or a regular registration has been completed beforehand, there will be no possibility of a refund.

Date

Signature