**Please send or fax to +49 (0)931 / 201-21248**

**Department of Otorhinolaryngology**

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**Conference Registration form (*Application is not submitted electronically)***

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| **Congress secretariat:**  Department of Otorhinolaryngology  University of Würzburg  Caroline Binder  Josef Schneider Str. 11  D-97080 Würzburg, Germany  Phone: +49 (0)931 / 201-21701  Fax: +49 (0)931 / 201-21248  🖳: [binder\_c@ukw.de](mailto:binder_c@klinik.uni-wuerzburg.de)  **www.hno.ukw.de**  **Course fees:**  **Early bird rate until Dec. 31st, 2017:**  300 € Course fee;  add. 220 € per session (180 min.) for temporal bone exercises  **Standard rate from January 1st, 2018:**  350 € Course fee;  add. 250 € per session (180 min.) for temporal bone exercises  **Confirmation letter:**  A confirmation letter will be sent upon receipt of your registration form.  Please inquire if confirmation does not reach you 2 weeks after your sending.  **Bank transfer:**  Please transfer your registration fee to the congress bank account **after receipt of confirmation:**  **Recipient:** Würzburg University Clinic  **IBAN:** DE73 7905 00000044610582  **BIC (Swift Code):** Byladem1SWU;  **Banking institution:**  Sparkasse Mainfranken Würzburg  **Notation for remittance:**  “ENT Department, account 8601467”, and additional your subscriber number  Precondition for participation in the temporal bone exercises is remittance **within two weeks after receiving our confirmation.** A processing fee of € 25 will be retained on all cancellations. Refunds will not be issued for cancella-tions after January 31st, 2018. | **Registration**  **I. Participation**  🗷 in the 30th Course on Microsurgery of the Middle Ear  **II. Individual subscription (please mark with a cross):**  Participation in the temporal bone exercises (one session about  180 min.)  Beginner  Professional  Participation in the social program on Monday, February 19th at  the Staatlicher Hofkeller Würzburg (included in the course fee);  Add. participant(s) (50 €): \_\_\_\_\_\_  **III. Participant**  (Please print your name as you wish it to appear on your badge)  Prof.  Dr.  Mr  Mrs  Other:  Family Name:  First Name:  Affiliation:  Street + number:  Postal code/City:  Country:  Work phone: ( )  Work fax: ( )  Email: @  Dietary requirements:    **Date: Signature: \_\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |