The 13th Scientific Meeting
The Asian Academy of Craniomandibular Disorders

REGISTRATION FORM

Office Use Only	Registration No. : _____	Date Received. : _____

PARTICIPANT

Name : (First) _____ (Last) _____

Degree/Specialty : _____ Position: _____

Clinic/Department : _____

Institute : _____

Address : _____

City/State : _____ Zip Code : _____ Country : _____

Phone : _____ Fax : _____ E-mail : _____

ACCOMPANYING PERSON(S)

Name : ☐ Mr. ☐Ms. (First) _____ (Last) _____

Name : ☐ Mr. ☐Ms. (First) _____ (Last) _____

RESISTRATION FEES

Classification	Before Aug.31.2010	After Sep. 1.2010	Number of person	Amoount
☐Member	☐JP¥10,000	☐JP¥15,000		
☐Non-Member	☐JP¥15,000	☐JP¥20,000		
☐Accompanying Person	☐JP¥5.000	☐JP¥10.000		
Total			JP¥_____	

PAYMENT METHOD

Send directly to the bank account only.
*Account: The Bank of FUKUOKA Ltd. Minamikokura branch, Kitakyushu, Japan, Swift Code:FKBKJPJT
1620113, AACMD JSOP SHUNJI SHIIBA
*Please indicate Resistrant's namein the "Application for Remittance" form and send a copy of the bank receipt confirming your remittance along with the registration form to the Organizing Committee

Please complete this form
and send it with your payment by mail or by fax or E-mail to the Organizing Committee

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