R E G I S T R A T I O N F O R M

The fields below with asterisk (\*) must be filled in.

|  |
| --- |
| **Date(s) to attend\*** |
| 🞏 6 January 2017 (Friday) 🞏 7 January 2017 (Saturday) 🞎 Request for Certificate of Attendance |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Information of Delegate** | | | | | | | | | | | | | |
| Title\* | | 🞏 Professor 🞏 Doctor 🞏 Mr 🞏 Mrs 🞏 Ms | | | | | | | | | | | |
| Gender | | 🞏 Male 🞏 Female | | | | | | | | | | | |
| Family Name\* | |  | | | Given Name\* | | |  | | | | | |
| Position\* | |  | | | Department\* | | |  | | | | | |
| Institution\* | |  | | | | | | | | | | | |
| Address\* | |  | | | | | | | | | | | |
| Country\* | |  | | | Tel\* |  | | | Fax | |  | | |
| E-mail\* | |  | | | | | | | | | | | |
| **Registration Category\*** | | | |  | | | | | |  | | | |
| Members of the below institutions/ societies | | | | | | | | | | Amount to be paid | | | |
| 🞏 Hong Kong Neurosurgical Society  🞏 Hong Kong Neurological Society  🞏 Hong Kong Neuro-Oncology Society  🞏 International Academy of Pathology, Hong Kong Division  🞎 The Hong Kong Movement Disorder Society  🞏 Students or staff of The Chinese University of Hong Kong  🞏 Staff of Prince of Wales Hospital / Hospitals in New Territories East Cluster (NTEC) | | | | | | | | | | Free | | | |
| Alumni of the below programme of CUHK | | | | | | | | | | Amount to be paid | | | |
| 🞏 Master of Science Programme in Neurological Sciences (NSSC)  🞏 Master of Science Programme in Stroke and Clinical Neurosciences (CNS) | | | | | | | | | | Free | | | |
| 🞏 Alumni of The Chinese University of Hong Kong 🞏 Students of other universities in Hong Kong 🞏 Staff of other hospitals of Hospital Authority | | | | | | | | | | HK$400 | | | |
| 🞏 Overseas delegates / Others | | | | | | | | | | HK$1,300 | | | |
| 🞎 Overseas delegates / Others (On-site registration) | | | | | | | | | | HK$2,000 | | | |
| **Payment Methods (If applicable)** | | | | | | | | | | | | |
| 🞏 | **Credit Card Payment** | | 🞏 Visa 🞏 MasterCard | | | | | | | | | |
|  | Cardholder’s Name | |  | | | | | | | | | |
|  | Card Number | |  | | | | Security Code# | | | | |  |
|  | Expiry Date (mm/yy) | |  | | | | Amount in HK$ | | | | |  |
|  | Signature of Cardholder | |  | | | | | | | | | |
| 🞏 | A bank draft / crossed cheque in HK$\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ made payable to "**The Chinese University of Hong Kong**" is enclosed.  Note:   1. Please write down your name and contact telephone number on the back of the bank draft/ cheque. 2. All bank charges must be paid by participant at source and only local cheques are acceptable. 3. No refund will be made once the payment is confirmed. | | | | | | | | | | | |
| # The last 3 digits in the signature area | | | | | | | | | | | | |
| |  |  |  | | --- | --- | --- | |  |  |  | | Signature of Delegate |  | Date | | | | | | | | | | | | | |
| Please send the completed registration form to the Congress Secretariat by email, fax or mail. | | | | | | | | | | | | |
| |  | | --- | | BRAIN2017  Division of Neurosurgery, Department of Surgery  The Chinese University of Hong Kong  4/F Lui Che Woo Clinical Sciences Building  Prince of Wales Hospital, Shatin, Hong Kong  Tel: (852) 2632 1316 / 2632 1852  Fax: (852) 2637 7974  E-mail: BRAIN2017@surgery.cuhk.edu.hk | | | | | | | | | | | | | |