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Identification

Please complete this section accurately. The information you provide will allow us to correspond with you efficiently.

5th International Congress of Intensive Care Medicine

Surname	<input type="text"/>
Initials	<input type="text"/>
First name	<input type="text"/>
Title (Titre)	<input type="checkbox"/> Prof. <input type="checkbox"/> Dr. <input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Ms.
Mailing Address	
Institute	<input type="text"/>
No.	<input type="text"/>
Street	<input type="text"/>
City	<input type="text"/>
Province	<input type="text"/>
Postal Code	<input type="text"/>
Telephone	<input type="text"/>
Fax	<input type="text"/>
Email	<input type="text"/>

Accompanying persons

Surname	<input type="text"/>	First name	<input type="text"/>
Surname	<input type="text"/>	First name	<input type="text"/>
Surname	<input type="text"/>	First name	<input type="text"/>

Please pay money inside congress

\$	Before August 22, 2005	Before September 23, 2005
Participant	100	150
Accompanying Pers	70	100
Resident \$ Trainees	50	75