REGISTRATION FORM

Name: Professor / Dr. / Mr. / Ms.: _____

Profession: Doctor / Nurse / Physiotherapist (PT) / Occupational Therapist (OT) / Others: _____

Job Title: _____

Department: _____

Hospital / Organization: _____

Address: _____

_____

Mobile Number: _____ Fax: _____

E-mail: _____

MEETING REGISTRATION

Category	Doctor	Allied Health Professionals
Members*	☐ HKD 150 per person	
Non-members	☐ HKD 600 per person	☐ HKD 400 per person

** Member of Hong Kong Thoracic Society or CHEST Delegation Hong Kong and Macau*

LUNCH REGISTRATION

☐ I shall join the lunch.

☐ I shall NOT join the lunch.

I enclose a cheque in the sum of HKD _____ as the registration fee.

Issuing Bank: _____ Cheque No.: _____

Signature: _____ Date: _____