



**Advanced Dry laparoscopic Workshop**

**23 April 2017 / 26 Rajab 1438**

**REGISTRATION FORM**

**Title: [ ] Prof. [ ] Dr.**

**Gender: [ ] Male [ ] Female**

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| First Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Middle Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Family Name |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Institution |  | | | | | | | | | | | | | |
| Position |  | | | | | | | Specialty: | | | | | | |
| **SCOHS**  **Registration ID.** |  | | | | | | | Valid until: | | | | | | |
| E-mail address |  | | | | | | | | | | | | | |
| Address |  | | | | | | | | | | | | | |
| P.O.Box |  | | | | | | | | | | | | | |
| Tel. No. | **Office No:** | | | | **Mobile:** | | | | **Fax No:** | | | | | |

**REGISTRATION FEES 1000 SR**

For More Information Please contact

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