



# American Healthcare Professionals and Friends for Medicine in Israel

2001 Beacon Street, Suite 210, Boston, MA 02135

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## Registration

### APF's Emergency and Disaster Preparedness Course in Israel

November 2<sup>nd</sup>\* - November 7<sup>th</sup>, 2019 \*After Shabbat

Name (as it appears on your Passport): \_\_\_\_\_

Mailing Address (including City, State, and Zip code): \_\_\_\_\_  
\_\_\_\_\_

Phone (including area code): (H) \_\_\_\_\_ (W) \_\_\_\_\_

E-Mail: \_\_\_\_\_

Specialty: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Passport Number (required for admission to some sites): \_\_\_\_\_

Passport Expiration: \_\_\_\_\_

(Please note that passport must be valid for a minimum of 6 months after entry into Israel)

\_\_\_\_\_ Please reserve a single room      \_\_\_\_\_ Please reserve a double room

I shall be sharing a room: Circle one of the following: Participant, Spouse Participant or Non-Participant

Accompanying Person's Name: \_\_\_\_\_

Specialty (if necessary): \_\_\_\_\_

Passport Number: (required for admission to some sites): \_\_\_\_\_

Expiration Date: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

(Please note that passports must be valid for a minimum of 6 months after entry into Israel)

In case of emergency please contact (include relationship, address and phone):  
\_\_\_\_\_  
\_\_\_\_\_

Credit card information number: \_\_\_\_\_ Exp.: \_\_\_\_\_ CVC: \_\_\_\_\_

Signature: \_\_\_\_\_ I agree to pay according to card issuer agreement

Please return this form with your \$500 deposit.

**Check, Credit Card or Online payments accepted** (Make checks payable to APF)

**American Physicians Fellowship for Medicine in Israel**

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