American Healthcare Professionals and Friends for Medicine in Israel
2001 Beacon Street, Suite 210, Boston, MA 02135

Registration

APF's Mission in Israel

May 3rd to 12th, 2023

Name (as it appears on your Passport): _____

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

_____

Phone (including area code): (H) _____ (Cell) _____

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 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)