

## COMPLETE NAME (To be printed on the Certificate)

**TITLE:** Dr. Prof. Mr. Mrs. Miss Others

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**GENDER:** Male Female

**REQUIRED:** Saudi Commission for Health Specialties License No. (1.e. 06-R-N-12345):

Institution/Hospital:	
Profession:	Telephone
Email Address:	Fax:
City/Postal Code	Mobile
Mailing Address/MBC:	

**Contact Information:** 

Carla Alvarez Mercado

**Congress Secretary** 

Phone: + 966-11-4647272 ext. 82123

E-mail: carlamercado@kfshrc.edu.sa

And the second s	<b>PAYMENT RECEIPT</b> <b>Registration fee:</b> (Cash Only; Onsite payment) Surgeons, Physicians, GP and Allied Health <u>- 400 SR</u>	Receipt No.: 2019-001-
SAUDI ARABIA	Students, Residents, Fellows – Free* (*Registration deadline	
Received from:		
Amount:		SR
Payment for:		
Received by:	Signature	