

RENAL DISEASE IN MINORITY POPULATIONS AND DEVELOPING NATIONS

Official WCN 2007 Post Congress Satellite Meeting
25 APRIL (4PM) to 27 APRIL (2 PM)
Rio de Janeiro, Brazil



PERSONAL PARTICULARS

Please tick **a** : Prof Dr Mr Ms Mrs

Name : _____

Hospital/Organization : _____

Mailing Address : _____

City/State : _____ Zip/Postal Code : _____ Country : _____

Tel : _____ Fax : _____

Email : _____

WCN 2007 Post Congress Satellite Meeting

Registration Charges

Number of Participants

Total Amount

RENAL DISEASE IN MINORITY POPULATIONS AND DEVELOPING NATIONS

US\$100.00

Mode of Payment (please **a** where appropriate)

Option 1 : Payment with Credit Card (please select one)

VISA

MASTER

AMEX

DINERS

JCB

Credit Card Number : _____ Expiry Date (MM/YY) : _____

Card Holder's Name : _____

I hereby authorize the organizing committee to charge my credit card a sum of _____ towards the registration fees for their satellite " RENAL DISEASE IN THE MINORITY POPULATIONS AND THE DEVELOPING NATIONS"

Signature of cardholder : _____ Date of Authorization : _____
(Authorizing Charge & Acknowledging Cancellation Policy) (dd/mm/yy)

CVV Number - Last 3 digits on the reverse side of the card :

Amex Verification Code - Last 4 digits present in front, right side of the card :

Option 2 : Payment by Wire Transfer (Telegraphic Transfer)

Telegraphic Transfer Number : _____

Name of the Bank : _____

Total Amount (Amount Payable + US 10 Bank Administrative charges) : _____

Please fax this form to :
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