**A Clear Vision for Radiology****REGISTRATION FOR ECR 2020,  
MARCH 11-15****REDUCED REGISTRATION FEE****Personal information**

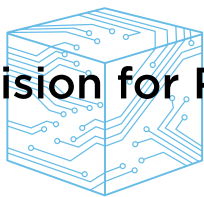
Title:		Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
First Name*:		Family Name*:	
Date of birth*:		Profession*:	
Hospital/Institute:			
Department:			
Street/No.*:			
ZIP Code*:	City*:	Country*:	
Phone:		Fax:	
E-mail*:			

\* required

**Registration details:**

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\*Please send a written confirmation signed by your head of department/hospital or professional representative body to verify your current professional status via e-mail to [proof@myESR.org](mailto:proof@myESR.org).



## A Clear Vision for Radiology

REGISTRATION FOR ECR 2020,  
MARCH 11-15

**REDUCED REGISTRATION FEE**

### Payment details

<input type="checkbox"/> Bank transfer
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### Important information:

Kindly note that this special reduced offer is only available if the completed registration form is sent to [congress@myesr.org](mailto:congress@myesr.org) **until October 17, 2019** at the latest.

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An e-mail containing the payment details will be sent to you. Once the registration payment is completed or a regular registration has been completed beforehand, there will be no possibility of a refund.

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Date

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Signature