The 70th Annual Meeting of Japanese Society of Allergology

REGISTRATION FORM

* Please fill in all fields in English
* Do not use specific characters or your own language such as Ä, á. or abbreviation.

**Registrant Information**

|  |  |
| --- | --- |
| Family Name |  |
| First Name |  |
| Middle Name |  |
| Date of Birth | MM/ DD/ YY |
| Affiliation  |  |
| Department |  |
| Category | [ ]  Doctor. [ ]  Medical Staff[ ]  Intern/ Student/ Patient advocacy group \*1 |

\*1 Please attach a copy of your student ID or resident certificate.

**Contact Information**

|  |  |
| --- | --- |
| Home / Office | [ ]  Home 　　 [ ]  Office |
| Postal Address |  |
| City |  |
| ZIP |  |
| Country |  |
| TEL |  |
| E-mail |  |