**REGISTRATION FORM**

**PARTICIPANT**

Mr Ms Dr

Family Name\*:

Name\*:

Institution:

Country\*:

Email\*:

**I will participate in\***:

- Conference (1.5 day)

- Conference + Team Physician training course (3 days)

**I need a visa support letter**:

- Yes

- No

**Note**: please return this form to [MedicalConference2019@unitedworldwrestling.org](mailto:MedicalConference2019@unitedworldwrestling.org) by 28 September. Upon reception, an invoice will be forwarded to you. The registration will be confirmed upon payment.

The registration fee will be 90 € per day and includes conference registration, lunch, coffee breaks and certificates. This registration does not comprise accommodation and transport.