

REGISTRATION FORM

Last Name		
First Name		Title: _____
Institution:		
Address		
PostalCode	City	Country
Telephone		FAX
Email		
Specialty		
IALMS Member		

*It is my intention to attend **Laser Florence 2008, October 31st - November 1st** as follows
Please indicate your choice(s) by ticking the appropriate box(es)*

SUBSCRIPTION FEE (VAT 20% included)

<i>MAIN MEETING</i>	SPEAKER or IALMS, ISLSM, IPTA Member	Non- Member	Accompanying person, Student, Nurse, Aesthetic Operator
Full Congress	EURO 550	EURO 650	EURO 400
One Day	EURO 500	EURO 550	EURO 350
Course	EURO 900	EURO 1100	EURO 540
TOTAL			

The **Meeting** Registration fee includes the entrance, volume 2009 (four issues) of peer Journal *Lasers in Medical Science*, official journal of the IALMS; free Laser Florence 2008 Abstracts book printed in a special issue of the same journal, a meeting bag with pen & notes, Welcome Cocktail, coffee-break and a light-lunch for the days of the Conference/Course.

The **Courses** registration fee include presentation of videotapes, live demonstration, and **discount of 20 % for the subscription fee at Laser Florence 2008 Meeting.**

NOTE:

THE SUBSCRIPTION FEE WILL INCREASE BY 20% AFTER JULY 30TH, 2008

**SUBSCRIPTION FEE BY E-MAIL OR POSTAL CARD WILL ACCEPT TILL OCTOBER 15TH, 2008
THE SUBSCRIPTION FEE WILL INCREASE BY 50% DURING THE MEETING DAYS**

Return of total subscription fee is possible until August 30th, 2008

(Except for 30% for VAT, bank and postal expenses).

After August 30th, 2008 the cancellation will NOT give return of subscription fee.

I send you with this form the total amount of the relevant fees (Please refer to the table on the following page)
 Payment may be made (**In Euros**) as follows:

- By certified bank cheque or draught, in favour of Laser Florence 2008
- By international money order in favour of Laser Florence 2008
- By direct bank transfer in favour of Astral srl (see details below)
- By credit card (fill in details below)

With the cheque No: _____ of the Bank: _____

Or the copy of the cheque No: _____ of the Bank _____

Or: I have made a bank transfer on (date): _____ From (Name of your bank) _____

(An official copy of the bank transfer should be enclosed with your reservation form)

Banco Posta Firenze, account Astral Srl, IBAN IT44 M 07601 02800 000081938920

BIC Code BPPIITRRXXX

Make bank transfers payable to

ASTRAL - BORGO PINTI, 57 I - 50121 FIRENZE

FAX 003905539069632 - E-MAIL: attendee@laserflorence.org

Or: I wish to pay by credit card, WITH SURCHARGE OF 5 %

Type of Card (MASTERCARD, VISA, DINERS, AMEX)
Card Number
Expiration Date: _____ Security Code _____
Cardholder's Signature

HOTEL ACCOMMODATION

Arrive	Departure	Type of room	First Class****	2 ND Class ***
		Double Room	EURO 250	EURO 180
		*Douse Room	EURO 210	EURO 150
		Single Room	EURO 180	EURO 130

*Douse room is double room for single use

- **Deadline for Hotel Reservation: OCTOBER 15th, 2008**

Please, send your fax or e-mail to ASTRAL for the reservation room before the deadline, with your number and type of Credit Card to confirm the reservation. **The Hotel will confirm your reservation directly with you.**

Mr. Diego can give you further details: diego@laserflorence.org

SOCIAL PROGRAM		Number of Participants
WELCOME COCKTAIL	FREE	
GALA DINNER WITH MUSIC and SHOW	EURO 200	