



PERSONAL INFORMATION

<input type="checkbox"/> Professor <input type="checkbox"/> Associate Professor <input type="checkbox"/> Dr <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Ms		
*Full Name (as per I.C./Passport):		
*I.C. Number/Passport Number:		
*Institution:		
*Address:		
City:	Country:	Postcode:
*Telephone:	*Mobile:	
*Email:		
<input type="checkbox"/> Cardiologist	<input type="checkbox"/> Nurse / Technician / Pharmacist	
<input type="checkbox"/> Internist	<input type="checkbox"/> Industry Employee	
<input type="checkbox"/> GP/Family Physician	<input type="checkbox"/> Young Investigator Award	
<input type="checkbox"/> Medical /Health Officers		

*Mandatory Fields

REGISTRATION FEES	RM	USD
Doctors and Allied Health Professionals (MSH members)	RM 750.00	-
Doctors and Allied Health Professionals (non-MSH members)	RM 800.00	-
International Delegates	-	USD 200.00
TOTAL REGISTRATION		

PAYMENT DETAILS

Cheque/Bank Draft

Please make the cheque/bankdraft payable to
"Persatuan Hipertensi Malaysia"

Cheque No.: _____

Issuing Bank: _____

Total Amount: **RM/USD** _____

Online Transfer to:

Beneficiary: **Persatuan Hipertensi Malaysia**

A/C Number: **620100173509**

Bank: **Standard Chartered Bank**

Branch: **Petaling Jaya**

Swift Code: **SCBLMYKXXXX**

Total Amount: **RM/USD** _____

Please email this form and proof of payment to the Event Organiser:

Email: msh.asm.secretariat@gmail.com Contact Person: **Ms Fay Cheah** Tel: **+6012 212 1328**

FOR OFFICIAL USE ONLY

Date Received:	Registration Number:
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