**Registration Form EVF HOW Plus Course:**

**“Venous Stenting and Thrombolysis Training Days”.**

**Wednesday-Thursday; November 7-8 2018**

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| **Title: Dr. Mr. Ms. Professor** | **Family Name:** | **First Name:** |
| **Home Address: ……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………**  **Work address:**  **……………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………………** | | |
| **E mail contact:** | **Mobile telephone:** | **Current Position:** |
| **How did you find out about this course?** | | |
| **Medical Speciality: (please indicate)**  **Interventional Radiologist, Vascular Surgeon, Angiologist, Phlebologist, Cardiovascular Surgeon, General Surgeon, Dermatologist, Gynaecologist, General Practitioner, Other**  **Comments:** | | |
| **How many venous procedures do you perform a month? Endovenous? Open?** | | |
| **Do you have sufficient endo-venous skills or sufficient experience of open vascular surgery to benefit from this course? Explain?** | | |
| **Interested in venous disease for how many years?** | | |
| **Work place setting: (please indicate):**  **University hospital, State hospital, Private Hospital, Private Office, Other** | | |
| **Special area of interest?** | | |
| **Highest Academic degree PhD, MD, Masters, Other** | | |
| **Attachments required:**  **Updated CV**  **Copy of License to Practice Medicine** | | |
| **I wish to attend The EVF HOW Plus Course:**  **“Venous Stenting and Thrombolysis Training Days” Wednesday – Thursday November 7-8 , 2018.**  **Venue: Department of Academic Surgery, 1st Floor North Wing, St Thomas' Hospital London UK.** | | |
| **Date: Wednesday- Thursday; November 7-8 , 2018** | | |
| **Course Fee: £300.00** | | |
| ***Photographs will be taken throughout the EVF HOW Plus Course; for sole use on our websites and social media platforms for the EVF. Please sign below to register for the course and also to consent to photographs being used for sole EVF purposes?***  **Signed: Date:** | | |

**Please send completed registration form: and copies of CV and License to Practice Medicine.**

**To: Dawn Bond email: evfhowplus@europeanvenousforum.org**